

AMENDED IN ASSEMBLY SEPTEMBER 6, 2011

AMENDED IN ASSEMBLY SEPTEMBER 2, 2011

AMENDED IN SENATE MAY 10, 2011

SENATE BILL

No. 946

**Introduced by ~~Committee on Health (Senators Hernandez (Chair),
Alquist, Anderson, Blakeslee, De León, DeSaulnier, Rubio,
Strickland, and Wolk)~~ Senators Steinberg and Evans**
(Principal coauthor: Senator Alquist)
(Principal coauthor: Assembly Member Beall)
**(Coauthors: Senators Corbett, DeSaulnier, Leno, Lieu, Liu, Padilla,
Pavley, and Wolk)**
*(Coauthors: Assembly Members Ammiano, Butler, Dickinson, Eng,
Fong, Mitchell, Portantino, Williams, and Yamada)*

March 31, 2011

An act to amend Sections 2028.5, 2290.5, and 3041 of the Business and Professions Code, to amend Section 78910.10 of the Education Code, to amend Sections 1367, 1375.1, 1797.98b, 113953.3, 113973, 121022, 123149.5, 127620, 130302, and 130307 of, to add Sections 113807 and 113975 to, and to repeal Sections 130304 and 130309 of, the Health and Safety Code, to amend Section 10123.13, 10123.147, 10181.11, 10198.7, 10953, and 10959 of the Insurance Code, and to amend Sections 5705, 5708, 5710, 5716, 5724, 5750.1, and 14132.73 of the Welfare and Institutions Code, relating to public health. *An act to amend Section 121022 of, to add Section 1374.74 to, and to add and repeal Section 1374.73 of, the Health and Safety Code, to add and repeal Sections 10144.51 and 10144.52 of the Insurance Code, and to amend Sections 5705, 5708, 5710, 5716, 5724, and 5750.1 of the Welfare and Institutions Code, relating to health.*

LEGISLATIVE COUNSEL'S DIGEST

SB 946, as amended, ~~Committee on Health Steinberg. Public health.~~
Health care coverage: mental illness: pervasive developmental disorder or autism: public health.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of these provisions is a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including certain mental health conditions.

This bill, effective July 1, 2012, would require those health care service plan contracts and health insurance policies, except as specified, to provide coverage for behavioral health treatment, as defined, for pervasive developmental disorder or autism. The bill would provide, however, that no benefits are required to be provided that exceed the essential health benefits that will be required under specified federal law. Because a violation of these provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

These provisions would be inoperative July 1, 2014, and repealed on January 1, 2015.

The bill would require the Department of Managed Health Care, in conjunction with the Department of Insurance, to convene an Autism Advisory Task Force by February 1, 2012, to provide assistance to the department on topics related to behavioral health treatment and to develop recommendations relating to the education, training, and experience requirements to secure licensure from the state. The bill would require the department to submit a report of the Task Force to the Governor and specified members of the Legislature by December 31, 2012.

~~(1) Existing law defines “telemedicine” for purposes of various provisions of existing law relating to the practice of medicine, among other things.~~

~~This bill would replace the term with “telehealth.”~~

~~(2) Existing law authorizes a county to establish an emergency medical services fund for reimbursement of emergency medical services (EMS)-related costs, and requires an annual report to the Legislature on the implementation and status of the fund, including the fund balance~~

and the amount of moneys disbursed to physicians and surgeons, for hospitals, and for other emergency medical services purposes.

This bill would require the report to provide additional information regarding the moneys collected and disbursed, including, but not limited to, a description of the other emergency medical services purposes, and the total amount of allowable claims submitted, if the moneys are disbursed to hospitals on a claims basis, and the names and contact information of the entity responsible for the collection and disbursement of prescribed funds. By increasing the duties of local officials, this bill would impose a state-mandated local program.

(3) Existing law, the California Retail Food Code, establishes uniform health and sanitation standards for retail food facilities, as defined. The law requires the State Department of Public Health to adopt regulations to implement and administer those provisions, and delegates primary enforcement duties to local health agencies. A violation of any of these provisions is punishable as a misdemeanor.

The code requires food employees to report to the person in charge of a food facility when a food employee has a lesion or wound that is open or draining unless specified conditions to cover or protect the lesion are met. The code requires all employees to wash their hands in specified instances, including before donning gloves for working with food. The code also requires gloves to be worn when contacting food and food-contact surfaces under specified conditions, including when the employee has any cuts, sores, or rashes. Gloves are required to be changed, replaced, or washed as often as hand washing is required.

This bill would require hands to be washed before initially donning gloves and before donning gloves after specified instances where gloves were required to be changed or replaced. The bill would prohibit single-use gloves from being washed. The bill would also prohibit an employee who has a lesion or wound that is open or draining from handling food and would require a food employee who has any cuts, sores, rashes, lesions, or wounds to cover or protect the lesion, as specified.

This bill would define “hotdog” for purposes of the code.

By changing the definition of a crime and increasing the duties of local enforcement officials, this bill would impose a state-mandated local program.

(4) Existing

Existing law establishes various communicable disease prevention and control programs. Existing law requires the State Department of

Public Health to establish a list of reportable diseases and conditions and requires health care providers and laboratories to report cases of HIV infection to the local health officer using patient names and sets guidelines regarding these reports. Existing law requires the local health officers to report unduplicated HIV cases by name to the department.

This bill would authorize the department to revise the HIV reporting form without the adoption of a regulation, as specified.

~~(5) Existing law, the Health Insurance Portability and Accountability Implementation Act of 2001, provides, until January 1, 2013, for an office in the California Health and Human Services Agency to assume statewide leadership and perform related activities for the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA). Under existing law, the director of the office is required to establish an advisory committee to obtain information on statewide activities to implement HIPAA that is required to meet, at a minimum, twice each year. Existing law required that, during 2002, state entities subject to HIPAA assess its impact on their operations and that the office report that information to the Legislature.~~

~~This bill would transfer responsibility for the statewide implementation of HIPAA to the Office of Health Information Integrity in the California Health and Human Services Agency. The bill would delete the requirement of 2 annual meetings for the advisory committee, providing for meetings as required for coordination purposes. The bill would also delete the assessment and reporting requirements for state entities and the office, which were required to be completed in 2002.~~

~~(6) Existing law, the federal Patient Protection and Affordable Care Act, prohibits a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition for children with respect to plan years beginning on or after September 23, 2010, and for adults with respect to plan years beginning on or after January 1, 2014.~~

~~Existing law prohibits the exclusion or limitation of health care coverage for children due to any preexisting condition, except as specified. Existing law requires a carrier to fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are offered and sold to a child in each service area in which the plan provides or arranges for health care coverage during any open enrollment period, as specified. Existing law imposes specified requirements on a carrier or solicitor when offering, marketing, or selling those plans.~~

~~This bill would make necessary technical changes to these provisions and correct erroneous cross-references. The bill would revise provisions that reference “solicitor” to instead refer to an agent or broker, as specified.~~

~~(7) Under~~

Under the Bronzan-McCorquodale Act, the State Department of Mental Health administers the provision of funds to counties for community mental health services programs. Existing law also permits counties to receive, under certain circumstances, Medi-Cal reimbursement for mental health services. Under existing law, negotiated net amounts or rates are used as the cost of services in contracts between the state and the county and between the county and a subprovider of services. Existing law establishes the method for computing negotiated rates. Existing law prohibits the charges for the care and treatment of each patient receiving service from a county mental health program from exceeding the actual or negotiated cost of the services.

This bill would only allow the use of negotiated net amounts as the cost of services in a contract between the state and a county and the county and a subprovider of services, and would eliminate the use of negotiated rates. The bill would also specify that the charges for the care and treatment of each patient receiving a service from a county mental health program shall not exceed the actual cost of the service.

~~(8) Existing~~

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Under existing law, the State Department of Health Care Services promulgates regulations for determining reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program. Existing law requires the State Department of Mental Health and the State Department of Health Care Services to jointly develop a ratesetting methodology for use in the Short-Doyle Medi-Cal system that maximizes federal funding and utilizes, as much as practicable, federal Medicare reimbursement principles. Existing law requires that this ratesetting methodology contain incentives relating to economy and efficiency.

The bill would delete the requirement that the ratesetting methodology in the Short-Doyle Medi-Cal system include incentives relating to economy and efficiency.

~~(9) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

~~With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.~~

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1374.73 is added to the Health and Safety
- 2 Code, to read:
- 3 1374.73. (a) (1) Every health care service plan contract
- 4 issued, amended, or renewed on or after July 1, 2012, that provides
- 5 hospital, medical, or surgical coverage shall provide coverage for
- 6 behavioral health treatment for pervasive developmental disorder
- 7 or autism. The coverage shall be provided in the same manner
- 8 and shall be subject to the same requirements as provided in
- 9 Section 1374.72.
- 10 (2) Notwithstanding paragraph (1), as of the date that proposed
- 11 final rulemaking for essential health benefits is issued, this section
- 12 does not require any benefits to be provided that exceed the
- 13 essential health benefits that all health plans will be required by
- 14 federal regulations to provide under Section 1302(b) of the federal
- 15 Patient Protection and Affordable Care Act (Public Law 111-148),
- 16 as amended by the federal Health Care and Education
- 17 Reconciliation Act of 2010 (Public Law 111-152).
- 18 (3) This section shall not affect services for which an individual
- 19 is eligible pursuant to Division 4.5 (commencing with Section

1 4500) of the Welfare and Institutions Code or Title 14 (commencing
2 with Section 95000) of the Government Code.

3 (4) This section shall not affect or reduce any obligation to
4 provide services under an individualized education program, as
5 defined in Section 56032 of the Education Code, or an
6 individualized service plan, as described in Section 5600.4 of the
7 Welfare and Institutions Code, or under the Individuals with
8 Disabilities Education Act (20 U.S.C. Sec. 1400, et seq.) and its
9 implementing regulations.

10 (b) Every health care service plan subject to this section shall
11 maintain an adequate network that includes qualified autism
12 service providers who supervise and employ qualified autism
13 service professionals or paraprofessionals who provide and
14 administer behavioral health treatment. Nothing shall prevent a
15 health care service plan from selectively contracting with providers
16 within these requirements.

17 (c) For the purposes of this section, the following definitions
18 shall apply:

19 (1) “Behavioral health treatment” means professional services
20 and treatment programs, including applied behavior analysis and
21 other behavior intervention programs, that develop or restore, to
22 the maximum extent practicable, the functioning of an individual
23 with pervasive developmental disorder or autism and that meet
24 all of the following criteria:

25 (A) The treatment is prescribed by a physician and surgeon
26 licensed pursuant to Chapter 5 (commencing with Section 2000)
27 of, or a psychologist licensed pursuant to Chapter 6.6 (commencing
28 with Section 2900) of, Division 2 of the Business and Professions
29 Code.

30 (B) The treatment is provided under a treatment plan prescribed
31 by a qualified autism service provider and is administered by one
32 of the following:

33 (i) A qualified autism service provider.

34 (ii) A qualified autism service professional supervised and
35 employed by the qualified autism service provider.

36 (iii) A qualified autism service paraprofessional supervised and
37 employed by a qualified autism service provider.

38 (C) The treatment plan has measurable goals over a specific
39 timeline that is developed and approved by the qualified autism
40 service provider for the specific patient being treated. The

1 *treatment plan shall be reviewed no less than once every six months*
2 *by the qualified autism service provider and modified whenever*
3 *appropriate, and shall be consistent with Section 4686.2 of the*
4 *Welfare and Institutions Code pursuant to which the qualified*
5 *autism service provider does all of the following:*

6 *(i) Describes the patient's behavioral health impairments to be*
7 *treated.*

8 *(ii) Designs an intervention plan that includes the service type,*
9 *number of hours, and parent participation needed to achieve the*
10 *plan's goal and objectives, and the frequency at which the patient's*
11 *progress is evaluated and reported.*

12 *(iii) Provides intervention plans that reflect evidence-based*
13 *practices, with demonstrated clinical efficacy in treating pervasive*
14 *developmental disorder or autism.*

15 *(iv) Discontinues intensive behavioral intervention services*
16 *when the treatment goals and objectives are achieved or no longer*
17 *appropriate.*

18 *(D) The treatment plan is not prescribed for purposes of*
19 *providing respite, day care, or school services and is not used to*
20 *reimburse a parent for participating in the treatment program.*
21 *The treatment plan shall be made available to the health care*
22 *service plan upon request.*

23 *(2) "Pervasive developmental disorder or autism" shall have*
24 *the same meaning and interpretation as used in Section 1374.72.*

25 *(3) "Qualified autism service provider" means either of the*
26 *following:*

27 *(A) A person, entity, or group that is certified by a national*
28 *entity, such as the Behavior Analyst Certification Board, that is*
29 *accredited by the National Commission for Certifying Agencies,*
30 *and who designs, supervises, or provides treatment for pervasive*
31 *developmental disorder or autism, provided the services are within*
32 *the experience and competence of the person, entity, or group that*
33 *is nationally certified.*

34 *(B) A person licensed as a physician and surgeon, physical*
35 *therapist, occupational therapist, psychologist, marriage and*
36 *family therapist, educational psychologist, clinical social worker,*
37 *professional clinical counselor, speech-language pathologist, or*
38 *audiologist pursuant to Division 2 (commencing with Section 500)*
39 *of the Business and Professions Code, who designs, supervises,*
40 *or provides treatment for pervasive developmental disorder or*

1 *autism, provided the services are within the experience and*
2 *competence of the licensee.*

3 *(4) “Qualified autism service professional” means an individual*
4 *who meets all of the following criteria:*

5 *(A) Provides behavioral health treatment.*

6 *(B) Is employed and supervised by a qualified autism service*
7 *provider.*

8 *(C) Provides treatment pursuant to a treatment plan developed*
9 *and approved by the qualified autism service provider.*

10 *(D) Is a behavioral service provider approved as a vendor by*
11 *a California regional center to provide services as an Associate*
12 *Behavior Analyst, Behavior Analyst, Behavior Management*
13 *Assistant, Behavior Management Consultant, or Behavior*
14 *Management Program as defined in Section 54342 of Title 17 of*
15 *the California Code of Regulations.*

16 *(E) Has training and experience in providing services for*
17 *pervasive developmental disorder or autism pursuant to Division*
18 *4.5 (commencing with Section 4500) of the Welfare and Institutions*
19 *Code or Title 14 (commencing with Section 95000) of the*
20 *Government Code.*

21 *(5) “Qualified autism service paraprofessional” means an*
22 *unlicensed and uncertified individual who meets all of the following*
23 *criteria:*

24 *(A) Is employed and supervised by a qualified autism service*
25 *provider.*

26 *(B) Provides treatment and implements services pursuant to a*
27 *treatment plan developed and approved by the qualified autism*
28 *service provider.*

29 *(C) Meets the criteria set forth in the regulations adopted*
30 *pursuant to Section 4686.3 of the Welfare and Institutions Code.*

31 *(D) Has adequate education, training, and experience, as*
32 *certified by a qualified autism service provider.*

33 *(d) This section shall not apply to the following:*

34 *(1) A specialized health care service plan that does not deliver*
35 *mental health or behavioral health services to enrollees.*

36 *(2) A health care service plan contract in the Medi-Cal program*
37 *(Chapter 7 (commencing with Section 14000) of Part 3 of Division*
38 *9 of the Welfare and Institutions Code).*

1 (3) A health care service plan contract in the Healthy Families
2 Program (Part 6.2 (commencing with Section 12693) of Division
3 2 of the Insurance Code).

4 (4) A health care benefit plan or contract entered into with the
5 Board of Administration of the Public Employees' Retirement
6 System pursuant to the Public Employees' Medical and Hospital
7 Care Act (Part 5 (commencing with Section 22750) of Division 5
8 of Title 2 of the Government Code).

9 (e) Nothing in this section shall be construed to limit the
10 obligation to provide services under Section 1374.72.

11 (f) Notwithstanding any other provision of law, in the provision
12 of benefits required by this section, a health care service plan may
13 utilize case management, network providers, utilization review
14 techniques, prior authorization, copayments, or other cost sharing.

15 (g) This section shall become inoperative on July 1, 2014, and,
16 as of January 1, 2015, is repealed, unless a later enacted statute,
17 that becomes operative on or before January 1, 2015, deletes or
18 extends the dates on which it becomes inoperative and is repealed.

19 SEC. 2. Section 1374.74 is added to the Health and Safety
20 Code, to read:

21 1374.74. (a) The department, in consultation with the
22 Department of Insurance, shall convene an Autism Advisory Task
23 Force by February 1, 2012, in collaboration with other agencies,
24 departments, advocates, autism experts, health plan and health
25 insurer representatives, and other entities and stakeholders that
26 it deems appropriate. The Autism Advisory Task Force shall
27 develop recommendations regarding behavioral health treatment
28 that is medically necessary for the treatment of individuals with
29 autism or pervasive developmental disorder. The Autism Advisory
30 Task Force shall address at the following:

31 (1) Interventions that have been scientifically validated and
32 have demonstrated clinical efficacy.

33 (2) Interventions that have measurable treatment outcomes.

34 (3) Patient selection, monitoring, and duration of therapy.

35 (4) Qualifications, training, and supervision of providers.

36 (5) Adequate networks of providers.

37 (b) The Autism Advisory Task Force shall also develop
38 recommendations regarding the education, training, and
39 experience requirements that unlicensed individuals providing

1 *autism services shall meet in order to secure a license from the*
2 *state.*

3 *(c) The department shall submit a report of the Autism Advisory*
4 *Task Force to the Governor, the President pro Tem of the Senate,*
5 *the Speaker of the Assembly, and the Senate and Assembly*
6 *Committees on Health by December 31, 2012, on which date the*
7 *task force shall cease to exist.*

8 ~~SECTION 1. Section 2028.5 of the Business and Professions~~
9 ~~Code is amended to read:~~

10 ~~2028.5. (a) The board may establish a pilot program to expand~~
11 ~~the practice of telemedicine, as defined in Section 2290.5, as it~~
12 ~~read on January 1, 2011, in this state.~~

13 ~~(b) To implement this pilot program, the board may convene a~~
14 ~~working group of interested parties from the public and private~~
15 ~~sectors, including, but not limited to, state health-related agencies,~~
16 ~~health care providers, health plan administrators, information~~
17 ~~technology groups, and groups representing health care consumers.~~

18 ~~(c) The purpose of the pilot program shall be to develop~~
19 ~~methods, using a telemedicine model, to deliver throughout the~~
20 ~~state health care to persons with chronic diseases as well as~~
21 ~~information on the best practices for chronic disease management~~
22 ~~services and techniques and other health care information as~~
23 ~~deemed appropriate.~~

24 ~~(d) The board shall make a report with its recommendations~~
25 ~~regarding its findings to the Legislature within one calendar year~~
26 ~~of the commencement date of the pilot program. The report shall~~
27 ~~include an evaluation of the improvement and affordability of~~
28 ~~health care services and the reduction in the number of~~
29 ~~complications achieved by the pilot program.~~

30 ~~SEC. 2. Section 2290.5 of the Business and Professions Code~~
31 ~~is amended to read:~~

32 ~~2290.5. (a) (1) For the purposes of this section, “telehealth”~~
33 ~~means the practice of health care delivery, diagnosis, consultation,~~
34 ~~treatment, transfer of medical data, and education using interactive~~
35 ~~audio, video, or data communications. Neither a telephone~~
36 ~~conversation nor an electronic mail message between a health care~~
37 ~~practitioner and patient constitutes “telehealth” for purposes of~~
38 ~~this section.~~

39 ~~(2) For purposes of this section, “interactive” means an audio,~~
40 ~~video, or data communication involving a real time (synchronous)~~

1 or near real time (asynchronous) two-way transfer of medical data
2 and information.

3 ~~(b) For the purposes of this section, “health care practitioner”~~
4 ~~has the same meaning as “licentiate” as defined in paragraph (2)~~
5 ~~of subdivision (a) of Section 805 and also includes a person~~
6 ~~licensed as an optometrist pursuant to Chapter 7 (commencing~~
7 ~~with Section 3000).~~

8 ~~(c) Prior to the delivery of health care via telehealth, the health~~
9 ~~care practitioner who has ultimate authority over the care or~~
10 ~~primary diagnosis of the patient shall obtain verbal and written~~
11 ~~informed consent from the patient or the patient’s legal~~
12 ~~representative. The informed consent procedure shall ensure that~~
13 ~~at least all of the following information is given to the patient or~~
14 ~~the patient’s legal representative verbally and in writing:~~

15 ~~(1) The patient or the patient’s legal representative retains the~~
16 ~~option to withhold or withdraw consent at any time without~~
17 ~~affecting the right to future care or treatment nor risking the loss~~
18 ~~or withdrawal of any program benefits to which the patient or the~~
19 ~~patient’s legal representative would otherwise be entitled.~~

20 ~~(2) A description of the potential risks, consequences, and~~
21 ~~benefits of telehealth.~~

22 ~~(3) All existing confidentiality protections apply.~~

23 ~~(4) All existing laws regarding patient access to medical~~
24 ~~information and copies of medical records apply.~~

25 ~~(5) Dissemination of any patient identifiable images or~~
26 ~~information from the telehealth interaction to researchers or other~~
27 ~~entities shall not occur without the consent of the patient.~~

28 ~~(d) A patient or the patient’s legal representative shall sign a~~
29 ~~written statement prior to the delivery of health care via telehealth,~~
30 ~~indicating that the patient or the patient’s legal representative~~
31 ~~understands the written information provided pursuant to~~
32 ~~subdivision (a), and that this information has been discussed with~~
33 ~~the health care practitioner, or his or her designee.~~

34 ~~(e) The written consent statement signed by the patient or the~~
35 ~~patient’s legal representative shall become part of the patient’s~~
36 ~~medical record.~~

37 ~~(f) The failure of a health care practitioner to comply with this~~
38 ~~section shall constitute unprofessional conduct. Section 2314 shall~~
39 ~~not apply to this section.~~

1 ~~(g) All existing laws regarding surrogate decisionmaking shall~~
2 ~~apply. For purposes of this section, “surrogate decisionmaking”~~
3 ~~means any decision made in the practice of medicine by a parent~~
4 ~~or legal representative for a minor or an incapacitated or~~
5 ~~incompetent individual.~~

6 ~~(h) Except as provided in paragraph (3) of subdivision (c), this~~
7 ~~section shall not apply when the patient is not directly involved in~~
8 ~~the telehealth interaction, for example when one health care~~
9 ~~practitioner consults with another health care practitioner.~~

10 ~~(i) This section shall not apply in an emergency situation in~~
11 ~~which a patient is unable to give informed consent and the~~
12 ~~representative of that patient is not available in a timely manner.~~

13 ~~(j) This section shall not apply to a patient under the jurisdiction~~
14 ~~of the Department of Corrections or any other correctional facility.~~

15 ~~(k) This section shall not be construed to alter the scope of~~
16 ~~practice of any health care provider or authorize the delivery of~~
17 ~~health care services in a setting, or in a manner, not otherwise~~
18 ~~authorized by law.~~

19 ~~SEC. 3.—Section 3041 of the Business and Professions Code is~~
20 ~~amended to read:~~

21 ~~3041. (a) The practice of optometry includes the prevention~~
22 ~~and diagnosis of disorders and dysfunctions of the visual system,~~
23 ~~and the treatment and management of certain disorders and~~
24 ~~dysfunctions of the visual system, as well as the provision of~~
25 ~~rehabilitative optometric services, and is the doing of any or all of~~
26 ~~the following:~~

27 ~~(1) The examination of the human eye or eyes, or its or their~~
28 ~~appendages, and the analysis of the human vision system, either~~
29 ~~subjectively or objectively.~~

30 ~~(2) The determination of the powers or range of human vision~~
31 ~~and the accommodative and refractive states of the human eye or~~
32 ~~eyes, including the scope of its or their functions and general~~
33 ~~condition.~~

34 ~~(3) The prescribing or directing the use of, or using, any optical~~
35 ~~device in connection with ocular exercises, visual training, vision~~
36 ~~training, or orthoptics.~~

37 ~~(4) The prescribing of contact and spectacle lenses for, or the~~
38 ~~fitting or adaptation of contact and spectacle lenses to, the human~~
39 ~~eye, including lenses that may be classified as drugs or devices by~~
40 ~~any law of the United States or of this state.~~

~~(5) The use of topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition.~~

~~(b) (1) An optometrist who is certified to use therapeutic pharmaceutical agents, pursuant to Section 3041.3, may also diagnose and treat the human eye or eyes, or any of its or their appendages, for all of the following conditions:~~

~~(A) Through medical treatment, infections of the anterior segment and adnexa, excluding the lacrimal gland, the lacrimal drainage system, and the sclera in patients under 12 years of age.~~

~~(B) Ocular allergies of the anterior segment and adnexa.~~

~~(C) Ocular inflammation, nonsurgical in cause except when comanaged with the treating physician and surgeon, limited to inflammation resulting from traumatic iritis, peripheral corneal inflammatory keratitis, episcleritis, and unilateral nonrecurrent nongranulomatous idiopathic iritis in patients over 18 years of age. Unilateral nongranulomatous idiopathic iritis recurring within one year of the initial occurrence shall be referred to an ophthalmologist. An optometrist shall consult with an ophthalmologist or appropriate physician and surgeon if a patient has a recurrent case of episcleritis within one year of the initial occurrence. An optometrist shall consult with an ophthalmologist or appropriate physician and surgeon if a patient has a recurrent case of peripheral corneal inflammatory keratitis within one year of the initial occurrence.~~

~~(D) Traumatic or recurrent conjunctival or corneal abrasions and erosions.~~

~~(E) Corneal surface disease and dry eyes.~~

~~(F) Ocular pain, nonsurgical in cause except when comanaged with the treating physician and surgeon, associated with conditions optometrists are authorized to treat.~~

~~(G) Pursuant to subdivision (f), glaucoma in patients over 18 years of age, as described in subdivision (j).~~

~~(2) For purposes of this section, “treat” means the use of therapeutic pharmaceutical agents, as described in subdivision (c), and the procedures described in subdivision (c).~~

~~(c) In diagnosing and treating the conditions listed in subdivision (b), an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may use all of the following therapeutic pharmaceutical agents:~~

1 ~~(1) Pharmaceutical agents as described in paragraph (5) of~~
2 ~~subdivision (a), as well as topical miotics.~~

3 ~~(2) Topical lubricants.~~

4 ~~(3) Antiallergy agents. In using topical steroid medication for~~
5 ~~the treatment of ocular allergies, an optometrist shall consult with~~
6 ~~an ophthalmologist if the patient's condition worsens 21 days after~~
7 ~~diagnosis.~~

8 ~~(4) Topical and oral antiinflammatories. In using steroid~~
9 ~~medication for:~~

10 ~~(A) Unilateral nonrecurrent nongranulomatous idiopathic iritis~~
11 ~~or episcleritis, an optometrist shall consult with an ophthalmologist~~
12 ~~or appropriate physician and surgeon if the patient's condition~~
13 ~~worsens 72 hours after the diagnosis, or if the patient's condition~~
14 ~~has not resolved three weeks after diagnosis. If the patient is still~~
15 ~~receiving medication for these conditions six weeks after diagnosis,~~
16 ~~the optometrist shall refer the patient to an ophthalmologist or~~
17 ~~appropriate physician and surgeon.~~

18 ~~(B) Peripheral corneal inflammatory keratitis, excluding~~
19 ~~Moorens and Terriens diseases, an optometrist shall consult with~~
20 ~~an ophthalmologist or appropriate physician and surgeon if the~~
21 ~~patient's condition worsens 72 hours after diagnosis.~~

22 ~~(C) Traumatic iritis, an optometrist shall consult with an~~
23 ~~ophthalmologist or appropriate physician and surgeon if the~~
24 ~~patient's condition worsens 72 hours after diagnosis and shall refer~~
25 ~~the patient to an ophthalmologist or appropriate physician and~~
26 ~~surgeon if the patient's condition has not resolved one week after~~
27 ~~diagnosis.~~

28 ~~(5) Topical antibiotic agents.~~

29 ~~(6) Topical hyperosmotics.~~

30 ~~(7) Topical and oral antiglaucoma agents pursuant to the~~
31 ~~certification process defined in subdivision (f).~~

32 ~~(A) The optometrist shall refer the patient to an ophthalmologist~~
33 ~~if requested by the patient or if angle closure glaucoma develops.~~

34 ~~(B) If the glaucoma patient also has diabetes, the optometrist~~
35 ~~shall consult with the physician treating the patient's diabetes in~~
36 ~~developing the glaucoma treatment plan and shall inform the~~
37 ~~physician in writing of any changes in the patient's glaucoma~~
38 ~~medication.~~

39 ~~(8) Nonprescription medications used for the rational treatment~~
40 ~~of an ocular disorder.~~

1 ~~(9) Oral antihistamines.~~

2 ~~(10) Prescription oral nonsteroidal antiinflammatory agents.~~

3 ~~(11) Oral antibiotics for medical treatment of ocular disease.~~

4 ~~(A) If the patient has been diagnosed with a central corneal ulcer~~
5 ~~and the central corneal ulcer has not improved 48 hours after~~
6 ~~diagnosis, the optometrist shall refer the patient to an~~
7 ~~ophthalmologist.~~

8 ~~(B) If the patient has been diagnosed with preseptal cellulitis~~
9 ~~or dacryocystitis and the condition has not improved 48 hours after~~
10 ~~diagnosis, the optometrist shall refer the patient to an~~
11 ~~ophthalmologist.~~

12 ~~(12) Topical and oral antiviral medication for the medical~~
13 ~~treatment of the following: herpes simplex viral keratitis, herpes~~
14 ~~simplex viral conjunctivitis, and periocular herpes simplex viral~~
15 ~~dermatitis; and varicella zoster viral keratitis, varicella zoster viral~~
16 ~~conjunctivitis, and periocular varicella zoster viral dermatitis.~~

17 ~~(A) If the patient has been diagnosed with herpes simplex~~
18 ~~keratitis or varicella zoster viral keratitis and the patient's condition~~
19 ~~has not improved seven days after diagnosis, the optometrist shall~~
20 ~~refer the patient to an ophthalmologist. If a patient's condition has~~
21 ~~not resolved three weeks after diagnosis, the optometrist shall refer~~
22 ~~the patient to an ophthalmologist.~~

23 ~~(B) If the patient has been diagnosed with herpes simplex viral~~
24 ~~conjunctivitis, herpes simplex viral dermatitis, varicella zoster~~
25 ~~viral conjunctivitis, or varicella zoster viral dermatitis, and if the~~
26 ~~patient's condition worsens seven days after diagnosis, the~~
27 ~~optometrist shall consult with an ophthalmologist. If the patient's~~
28 ~~condition has not resolved three weeks after diagnosis, the~~
29 ~~optometrist shall refer the patient to an ophthalmologist.~~

30 ~~(13) Oral analgesics that are not controlled substances.~~

31 ~~(14) Codeine with compounds and hydrocodone with~~
32 ~~compounds as listed in the California Uniform Controlled~~
33 ~~Substances Act (Division 10 (commencing with Section 11000)~~
34 ~~of the Health and Safety Code) and the United States Uniform~~
35 ~~Controlled Substances Act (21 U.S.C. Sec. 801 et seq.). The use~~
36 ~~of these agents shall be limited to three days, with a referral to an~~
37 ~~ophthalmologist if the pain persists.~~

38 ~~(d) In any case where this chapter requires that an optometrist~~
39 ~~consult with an ophthalmologist, the optometrist shall maintain a~~
40 ~~written record in the patient's file of the information provided to~~

1 the ophthalmologist, the ophthalmologist's response, and any other
2 relevant information. Upon the consulting ophthalmologist's
3 request and with the patient's consent, the optometrist shall furnish
4 a copy of the record to the ophthalmologist.

5 (e) An optometrist who is certified to use therapeutic
6 pharmaceutical agents pursuant to Section 3041.3 may also perform
7 all of the following:

8 (1) Corneal scraping with cultures.

9 (2) Debridement of corneal epithelia.

10 (3) Mechanical epilation.

11 (4) Venipuncture for testing patients suspected of having
12 diabetes.

13 (5) Suture removal, with prior consultation with the treating
14 physician and surgeon.

15 (6) Treatment or removal of sebaceous cysts by expression.

16 (7) Administration of oral fluorescein to patients suspected as
17 having diabetic retinopathy.

18 (8) Use of an auto-injector to counter anaphylaxis.

19 (9) Ordering of smears, cultures, sensitivities, complete blood
20 count, mycobacterial culture, acid fast stain, urinalysis, and X-rays
21 necessary for the diagnosis of conditions or diseases of the eye or
22 adnexa. An optometrist may order other types of images subject
23 to prior consultation with an ophthalmologist or appropriate
24 physician and surgeon.

25 (10) Punctal occlusion by plugs, excluding laser, diathermy,
26 cryotherapy, or other means constituting surgery as defined in this
27 chapter.

28 (11) The prescription of therapeutic contact lenses, including
29 lenses or devices that incorporate a medication or therapy the
30 optometrist is certified to prescribe or provide.

31 (12) Removal of foreign bodies from the cornea, eyelid, and
32 conjunctiva with any appropriate instrument other than a scalpel
33 or needle. Corneal foreign bodies shall be nonperforating, be no
34 deeper than the midstroma, and require no surgical repair upon
35 removal.

36 (13) For patients over 12 years of age, lacrimal irrigation and
37 dilation, excluding probing of the nasal lacrimal tract. The board
38 shall certify any optometrist who graduated from an accredited
39 school of optometry before May 1, 2000, to perform this procedure
40 after submitting proof of satisfactory completion of 10 procedures

1 under the supervision of an ophthalmologist as confirmed by the
2 ophthalmologist. Any optometrist who graduated from an
3 accredited school of optometry on or after May 1, 2000, shall be
4 exempt from the certification requirement contained in this
5 paragraph.

6 (f) The board shall grant a certificate to an optometrist certified
7 pursuant to Section 3041.3 for the treatment of glaucoma, as
8 described in subdivision (j), in patients over 18 years of age after
9 the optometrist meets the following applicable requirements:

10 (1) For licensees who graduated from an accredited school of
11 optometry on or after May 1, 2008, submission of proof of
12 graduation from that institution.

13 (2) For licensees who were certified to treat glaucoma under
14 this section prior to January 1, 2009, submission of proof of
15 completion of that certification program.

16 (3) For licensees who have substantially completed the
17 certification requirements pursuant to this section in effect between
18 January 1, 2001, and December 31, 2008, submission of proof of
19 completion of those requirements on or before December 31, 2009.
20 “Substantially completed” means both of the following:

21 (A) Satisfactory completion of a didactic course of not less than
22 24 hours in the diagnosis, pharmacological, and other treatment
23 and management of glaucoma.

24 (B) Treatment of 50 glaucoma patients with a collaborating
25 ophthalmologist for a period of two years for each patient that will
26 conclude on or before December 31, 2009.

27 (4) For licensees who completed a didactic course of not less
28 than 24 hours in the diagnosis, pharmacological, and other
29 treatment and management of glaucoma, submission of proof of
30 satisfactory completion of the case management requirements for
31 certification established by the board pursuant to Section 3041.10.

32 (5) For licensees who graduated from an accredited school of
33 optometry on or before May 1, 2008, and not described in
34 paragraph (2), (3), or (4), submission of proof of satisfactory
35 completion of the requirements for certification established by the
36 board pursuant to Section 3041.10.

37 (g) Other than for prescription ophthalmic devices described in
38 subdivision (b) of Section 2541, any dispensing of a therapeutic
39 pharmaceutical agent by an optometrist shall be without charge.

1 ~~(h) The practice of optometry does not include performing~~
2 ~~surgery. “Surgery” means any procedure in which human tissue~~
3 ~~is cut, altered, or otherwise infiltrated by mechanical or laser~~
4 ~~means. “Surgery” does not include those procedures specified in~~
5 ~~subdivision (e). Nothing in this section shall limit an optometrist’s~~
6 ~~authority to utilize diagnostic laser and ultrasound technology~~
7 ~~within his or her scope of practice.~~

8 ~~(i) An optometrist licensed under this chapter is subject to~~
9 ~~Section 2290.5 for purposes of practicing telehealth.~~

10 ~~(j) For purposes of this chapter, “glaucoma” means either of the~~
11 ~~following:~~

12 ~~(1) All primary open-angle glaucoma.~~

13 ~~(2) Exfoliation and pigmentary glaucoma.~~

14 ~~(k) In an emergency, an optometrist shall stabilize, if possible,~~
15 ~~and immediately refer any patient who has an acute attack of angle~~
16 ~~closure to an ophthalmologist.~~

17 ~~SEC. 4. Section 78910.10 of the Education Code is amended~~
18 ~~to read:~~

19 ~~78910.10. (a) (1) The California Virtual Campus, pursuant~~
20 ~~to funding provided to the Board of Governors of the California~~
21 ~~Community Colleges for this purpose in the annual Budget Act,~~
22 ~~may pursue all of the following purposes, to the extent funding is~~
23 ~~available:~~

24 ~~(A) To enrich formal and informal educational experiences and~~
25 ~~improve students’ academic performance by supporting the~~
26 ~~development of highly engaging, research-based innovations in~~
27 ~~teaching and learning in K-12 public schools and the California~~
28 ~~Community Colleges, the California State University, and the~~
29 ~~University of California.~~

30 ~~(B) To enhance the awareness of, and access to, highly engaging~~
31 ~~online courses of study, emphasizing courses of study that support~~
32 ~~a diverse and highly skilled science, technology, engineering, and~~
33 ~~mathematics workforce.~~

34 ~~(C) To support education research, the implementation of~~
35 ~~research-based practices, and promote economic development~~
36 ~~through the use of next generation advanced network infrastructure,~~
37 ~~services, and network technologies that enable collaboration and~~
38 ~~resource sharing between formal and informal educators in K-12~~
39 ~~public schools, the California Community Colleges, the California~~
40 ~~State University, the University of California, independent colleges~~

1 and—universities,—public—libraries,—and—community-based
2 organizations at locations across the state.

3 (D) To increase access to next generation Internet services, 21st
4 century workforce development programs, and e-government
5 services for students and staff served or employed by education
6 entities and students served primarily online through partnerships
7 with public libraries and community-based organizations.

8 (E) To enhance access to health care education and training
9 programs to current or future health care workers.

10 (F) To manage digital assets and develop contracts for services
11 necessary to provide the technical and management support needed
12 to maximize the benefits of the high-speed, high-bandwidth
13 network infrastructure available to public higher education entities
14 in California.

15 (G) Through the aggregation of demand for network enabled
16 technologies and related services from public education entities,
17 and through partnerships with the private sector, to provide
18 education entities with access to technical support and staff who
19 can facilitate statewide efforts that support innovations in teaching
20 and learning that are necessary to provide for a well-educated
21 citizenry, and economic and 21st century workforce development.

22 (2) To accomplish the purposes of paragraph (1), the California
23 Virtual Campus may partner with local educational agencies, the
24 State Department of Education, the 11 regional California
25 Technology Assistance Projects, the California Community
26 Colleges, the California State University, the University of
27 California, independent colleges and universities, public libraries,
28 and community-based organizations to facilitate ongoing
29 collaboration and joint efforts relating to the use of technology
30 resources and high-speed Internet connectivity to support teaching,
31 learning, workforce development, and research.

32 (3) Efforts conducted as a result of this chapter shall not prohibit
33 or otherwise exclude the ability of existing or new educational
34 technology programs from being developed, expanded, or
35 enhanced.

36 (b) For purposes of this article, the following terms have the
37 following meanings:

38 (1) “Online courses of study” means any of the following:

39 (A) Online teaching, learning, and research resources, including,
40 but not necessarily limited to, books, course materials, video

1 materials, interactive lessons, tests, or software, the copyrights of
2 which have expired, or have been released with an intellectual
3 property license that permits their free use or repurposing by others
4 without the permission of the original authors or creators of the
5 learning materials or resources.

6 ~~(B) Professional development opportunities for formal and~~
7 ~~informal educators who desire to use the resources in subparagraph~~
8 ~~(A).~~

9 ~~(C) Online instruction:~~

10 ~~(2) “Online instruction” means technology enabled online real~~
11 ~~time (synchronous) interaction between the instructor and the~~
12 ~~student, near time (asynchronous) interaction between the instructor~~
13 ~~and the student, or any combination thereof.~~

14 ~~(e) The California Virtual Campus grant recipient may~~
15 ~~accomplish all of the following:~~

16 ~~(1) Convene at least four leadership stakeholder group meetings~~
17 ~~annually comprised of representatives from the State Department~~
18 ~~of Education, the California Technology Assistance Project, and~~
19 ~~other related programs administered through the department, local~~
20 ~~education agencies, including adult education, the California~~
21 ~~Community Colleges, the California State University, the~~
22 ~~University of California, independent colleges and universities,~~
23 ~~the California State Library, and representatives from~~
24 ~~community-based organizations to ensure the efforts affecting~~
25 ~~segments represented are appropriately meeting the needs of those~~
26 ~~segments. The leadership stakeholder group shall also coordinate~~
27 ~~and obtain assistance with the implementation of efforts delineated~~
28 ~~in this article, to identify and maintain an up-to-date list of the~~
29 ~~technology resources and tools that are necessary to support~~
30 ~~innovation in teaching and learning, and to identify opportunities~~
31 ~~for leveraging resources and expertise for meeting those needs in~~
32 ~~an efficient and cost-effective manner.~~

33 ~~(2) Lead efforts to make online courses of study available across~~
34 ~~the state that include, but are not limited to, the following:~~

35 ~~(A) Developing online courses of study that are pedagogically~~
36 ~~sound and fully accessible, in compliance with the federal~~
37 ~~Americans with Disabilities Act of 1990 (Public Law 101-336),~~
38 ~~by students with varying learning styles and disabilities.~~

1 ~~(i) The development of K-12 online courses pursuant to this~~
2 ~~subparagraph shall be achieved in partnership with local education~~
3 ~~agencies and the California Technology Assistance Project.~~

4 ~~(ii) Online courses developed for grades K-12 pursuant to this~~
5 ~~subparagraph shall be aligned to the California academic content~~
6 ~~standards and guidelines for online courses.~~

7 ~~(B) Overseeing the development of at least 12 model online~~
8 ~~courses of study that, collectively, would allow students to meet~~
9 ~~the requirements of the Intersegmental General Education Transfer~~
10 ~~Curriculum (IGETC) and at least two courses that support basic~~
11 ~~skills education courses in English, English as a second language,~~
12 ~~or mathematics.~~

13 ~~(C) Encouraging the entities listed in paragraph (1) to do both~~
14 ~~of the following:~~

15 ~~(i) Make accessible to each other their courses of study that are~~
16 ~~funded by the state.~~

17 ~~(ii) Allow their courses of study to be accessible to the general~~
18 ~~public if they determine access would not inhibit their ability to~~
19 ~~provide appropriate protection of the state's intellectual property~~
20 ~~rights.~~

21 ~~(3) Ensure that the learning objects created as part of the~~
22 ~~California Virtual Campus online courses of study with state~~
23 ~~General Fund revenues are linked to digital content libraries that~~
24 ~~include information about course content freely available to~~
25 ~~California educators and students.~~

26 ~~(4) Develop formal partnership agreements between the entities~~
27 ~~listed in paragraph (1) and the California Virtual Campus, including~~
28 ~~course articulation agreements that allow qualified high school~~
29 ~~students to accelerate the completion of requirements for a high~~
30 ~~school diploma and a two-year or four-year degree and agreements~~
31 ~~that provide opportunities for part-time faculty teaching online to~~
32 ~~obtain full-time employment teaching online.~~

33 ~~(5) Develop formal partnership agreements with the entities~~
34 ~~listed in paragraph (1) and others to enhance access to professional~~
35 ~~development courses that introduce faculty, teachers, staff, and~~
36 ~~college course developers to the conceptual development, creation,~~
37 ~~and production methodologies that underlie the development of~~
38 ~~online courses of study and support students' successful completion~~
39 ~~of those courses. The professional development opportunities may~~
40 ~~include, but not necessarily be limited to, all of the following:~~

1 ~~(A) Addressing issues relating to copyright, permission for the~~
2 ~~use or reuse of material, use of resources in the public domain,~~
3 ~~and other intellectual property concepts.~~

4 ~~(B) Accessibility for students with disabilities.~~

5 ~~(C) Factors to ensure that content is culturally relevant to a~~
6 ~~diverse student body.~~

7 ~~(D) Delivery options that incorporate multiple learning styles~~
8 ~~and strategies.~~

9 ~~(6) Develop formal partnership agreements with entities,~~
10 ~~including, but not limited to, those listed in paragraph (1), to ensure~~
11 ~~access to online professional learning communities that incorporate~~
12 ~~the use of Internet-based collaboration tools and to support joint~~
13 ~~discussions between K-12 educators, higher education faculty and~~
14 ~~staff, and others to examine student performance data, student~~
15 ~~learning objectives, curriculum, and other issues that relate to~~
16 ~~students' academic success and preparation for the workforce.~~

17 ~~(7) In partnership with entities, including those listed in~~
18 ~~paragraph (1), develop an e-portfolio system that allows~~
19 ~~participating students to demonstrate their attainment of academic~~
20 ~~learning objectives, skills and knowledge that relate to their career~~
21 ~~interests, and completion of prerequisites for participation in~~
22 ~~courses or training programs. The e-portfolio system may do all~~
23 ~~of the following:~~

24 ~~(A) Ensure that student privacy is protected in accordance with~~
25 ~~existing law.~~

26 ~~(B) Comply with accessibility laws for students with disabilities.~~

27 ~~(C) Be designed in a manner that supports the use of e-portfolio~~
28 ~~content in the accreditation requirements of schools, colleges, and~~
29 ~~universities.~~

30 ~~(8) In partnership with entities, including those listed in~~
31 ~~paragraph (1), identify opportunities to enhance students' access~~
32 ~~to medical education and medical services through the use of~~
33 ~~high-speed Internet connections to the campuses, and opportunities~~
34 ~~for education programs and services to support the telehealth efforts~~
35 ~~taking place within the state.~~

36 ~~(d) The lead agency for the California Virtual Campus, in~~
37 ~~consultation with the leadership stakeholder group described in~~
38 ~~paragraph (1) of subdivision (c) if that group is convened by the~~
39 ~~California Virtual Campus grant recipient, shall contract with an~~
40 ~~independent third party with expertise in online teaching, learning,~~

1 and the development of online courses of study, as approved by
2 the board, to evaluate the California Virtual Campus. The
3 evaluation shall include, but not be limited to, an assessment of
4 the number of faculty, teachers, consortia, informal educators, and
5 students that use the online courses of study, the quality of students'
6 experiences, student grades earned, and the cost of the online
7 course content, comparing the online course content with traditional
8 textbooks. The board may require additional information that it
9 determines to be necessary to evaluate the effectiveness and
10 viability of the California Virtual Campus. This evaluation shall
11 be submitted to the Legislature no later than three years of the
12 enactment of this act.

13 SEC. 5. Section 1367 of the Health and Safety Code is amended
14 to read:

15 1367. A health care service plan and, if applicable, a specialized
16 health care service plan shall meet the following requirements:

17 (a) Facilities located in this state including, but not limited to,
18 clinics, hospitals, and skilled nursing facilities to be utilized by
19 the plan shall be licensed by the State Department of Public Health,
20 where licensure is required by law. Facilities not located in this
21 state shall conform to all licensing and other requirements of the
22 jurisdiction in which they are located.

23 (b) Personnel employed by or under contract to the plan shall
24 be licensed or certified by their respective board or agency, where
25 licensure or certification is required by law.

26 (c) Equipment required to be licensed or registered by law shall
27 be so licensed or registered, and the operating personnel for that
28 equipment shall be licensed or certified as required by law.

29 (d) The plan shall furnish services in a manner providing
30 continuity of care and ready referral of patients to other providers
31 at times as may be appropriate consistent with good professional
32 practice.

33 (e) (1) All services shall be readily available at reasonable
34 times to each enrollee consistent with good professional practice.
35 To the extent feasible, the plan shall make all services readily
36 accessible to all enrollees consistent with Section 1367.03.

37 (2) To the extent that telehealth services are appropriately
38 provided through telehealth, as defined in subdivision (a) of Section
39 2290.5 of the Business and Professions Code, these services shall

1 be considered in determining compliance with Section 1300.67.2
2 of Title 28 of the California Code of Regulations.

3 (3) The plan shall make all services accessible and appropriate
4 consistent with Section 1367.04.

5 (f) The plan shall employ and utilize allied health manpower
6 for the furnishing of services to the extent permitted by law and
7 consistent with good medical practice.

8 (g) The plan shall have the organizational and administrative
9 capacity to provide services to subscribers and enrollees. The plan
10 shall be able to demonstrate to the department that medical
11 decisions are rendered by qualified medical providers, unhindered
12 by fiscal and administrative management.

13 (h) (1) Contracts with subscribers and enrollees, including
14 group contracts, and contracts with providers, and other persons
15 furnishing services, equipment, or facilities to or in connection
16 with the plan, shall be fair, reasonable, and consistent with the
17 objectives of this chapter. All contracts with providers shall contain
18 provisions requiring a fast, fair, and cost-effective dispute
19 resolution mechanism under which providers may submit disputes
20 to the plan, and requiring the plan to inform its providers upon
21 contracting with the plan, or upon change to these provisions, of
22 the procedures for processing and resolving disputes, including
23 the location and telephone number where information regarding
24 disputes may be submitted.

25 (2) A health care service plan shall ensure that a dispute
26 resolution mechanism is accessible to noncontracting providers
27 for the purpose of resolving billing and claims disputes.

28 (3) On and after January 1, 2002, a health care service plan
29 shall annually submit a report to the department regarding its
30 dispute resolution mechanism. The report shall include information
31 on the number of providers who utilized the dispute resolution
32 mechanism and a summary of the disposition of those disputes.

33 (i) A health care service plan contract shall provide to
34 subscribers and enrollees all of the basic health care services
35 included in subdivision (b) of Section 1345, except that the director
36 may, for good cause, by rule or order exempt a plan contract or
37 any class of plan contracts from that requirement. The director
38 shall by rule define the scope of each basic health care service that
39 health care service plans are required to provide as a minimum for
40 licensure under this chapter. Nothing in this chapter shall prohibit

1 a health care service plan from charging subscribers or enrollees
2 a copayment or a deductible for a basic health care service or from
3 setting forth, by contract, limitations on maximum coverage of
4 basic health care services, provided that the copayments,
5 deductibles, or limitations are reported to, and held unobjectionable
6 by, the director and set forth to the subscriber or enrollee pursuant
7 to the disclosure provisions of Section 1363.

8 (j) A health care service plan shall not require registration under
9 the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.)
10 as a condition for participation by an optometrist certified to use
11 therapeutic pharmaceutical agents pursuant to Section 3041.3 of
12 the Business and Professions Code.

13 Nothing in this section shall be construed to permit the director
14 to establish the rates charged subscribers and enrollees for
15 contractual health care services.

16 The director's enforcement of Article 3.1 (commencing with
17 Section 1357) shall not be deemed to establish the rates charged
18 subscribers and enrollees for contractual health care services.

19 The obligation of the plan to comply with this section shall not
20 be waived when the plan delegates any services that it is required
21 to perform to its medical groups, independent practice associations,
22 or other contracting entities.

23 SEC. 6. Section 1375.1 of the Health and Safety Code is
24 amended to read:

25 1375.1. (a) Every plan shall have and shall demonstrate to the
26 director that it has all of the following:

27 (1) A fiscally sound operation and adequate provision against
28 the risk of insolvency.

29 (2) Assumed full financial risk on a prospective basis for the
30 provision of covered health care services, except that a plan may
31 obtain insurance or make other arrangements for the cost of
32 providing to any subscriber or enrollee covered health care services;
33 the aggregate value of which exceeds five thousand dollars (\$5,000)
34 in any year, for the cost of covered health care services provided
35 to its members other than through the plan because medical
36 necessity required their provision before they could be secured
37 through the plan, and for not more than 90 percent of the amount
38 by which its costs for any of its fiscal years exceed 115 percent of
39 its income for that fiscal year.

1 ~~(3) A procedure for prompt payment or denial of provider and~~
2 ~~subscriber or enrollee claims, including those telehealth services,~~
3 ~~as defined in subdivision (a) of Section 2290.5 of the Business and~~
4 ~~Professions Code, covered by the plan. Except as provided in~~
5 ~~Section 1371, a procedure meeting the requirements of Subchapter~~
6 ~~G of the regulations (29 C.F.R. Part 2560) under Public Law~~
7 ~~93-406 (88 Stats. 829-1035, 29 U.S.C. Secs. 1001 et seq.) shall~~
8 ~~satisfy this requirement.~~

9 ~~(b) In determining whether the conditions of this section have~~
10 ~~been met, the director shall consider, but not be limited to, the~~
11 ~~following:~~

12 ~~(1) The financial soundness of the plan's arrangements for health~~
13 ~~care services and the schedule of rates and charges used by the~~
14 ~~plan.~~

15 ~~(2) The adequacy of working capital.~~

16 ~~(3) Agreements with providers for the provision of health care~~
17 ~~services.~~

18 ~~(e) For the purposes of this section, "covered health care~~
19 ~~services" means health care services provided under all plan~~
20 ~~contracts.~~

21 ~~SEC. 7. Section 1797.98b of the Health and Safety Code is~~
22 ~~amended to read:~~

23 ~~1797.98b. (a) Each county establishing a fund, on January 1,~~
24 ~~1989, and on each April 15 thereafter, shall report to the Legislature~~
25 ~~on the implementation and status of the Emergency Medical~~
26 ~~Services Fund. The report shall cover the preceding fiscal year,~~
27 ~~and shall include, but not be limited to, all of the following:~~

28 ~~(1) The total amount of fines and forfeitures collected, the total~~
29 ~~amount of penalty assessments collected, and the total amount of~~
30 ~~penalty assessments deposited into the Emergency Medical~~
31 ~~Services Fund, or, if no moneys were deposited into the fund, the~~
32 ~~reason or reasons for the lack of deposits. The total amounts of~~
33 ~~penalty assessments shall be listed on the basis of each statute that~~
34 ~~provides the authority for the penalty assessment, including~~
35 ~~Sections 76000, 76000.5, and 76104 of the Government Code, and~~
36 ~~Section 42007 of the Vehicle Code.~~

37 ~~(2) The amount of penalty assessment funds collected under~~
38 ~~Section 76000.5 of the Government Code that are used for the~~
39 ~~purposes of subdivision (c) of Section 1797.98a.~~

~~(3) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes, and the amount of money disbursed for actual administrative costs. If funds were disbursed for other emergency medical services, the report shall provide a description of each of those services.~~

~~(4) The number of claims paid to physicians and surgeons, and the percentage of claims paid, based on the uniform fee schedule, as adopted by the county.~~

~~(5) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.~~

~~(6) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.~~

~~(7) The name of the physician and surgeon and hospital administrator organization, or names of specific physicians and surgeons and hospital administrators, contacted to review claims payment methodologies.~~

~~(8) A description of the process used to solicit input from physicians and surgeons and hospitals to review payment distribution methodology as described in subdivision (a) of Section 1797.98e.~~

~~(9) An identification of the fee schedule used by the county pursuant to subdivision (e) of Section 1797.98e.~~

~~(10) (A) A description of the methodology used to disburse moneys to hospitals pursuant to subparagraph (B) of paragraph (5) of subdivision (b) of Section 1797.98a.~~

~~(B) The amount of moneys available to be disbursed to hospitals.~~

~~(C) If moneys are disbursed to hospitals on a claims basis, the dollar amount of the total allowable claims submitted and the percentage at which those claims were reimbursed to hospitals.~~

~~(11) The name and contact information of the entity responsible for each of the following:~~

~~(A) Collection of fines, forfeitures, and penalties.~~

~~(B) Distribution of penalty assessments into the Emergency Medical Services Fund.~~

~~(C) Distribution of moneys to physicians and surgeons.~~

1 ~~(b) (1) Each county, upon request, shall make available to any~~
2 ~~member of the public the report required under subdivision (a):~~

3 ~~(2) Each county, upon request, shall make available to any~~
4 ~~member of the public a listing of physicians and surgeons and~~
5 ~~hospitals that have received reimbursement from the Emergency~~
6 ~~Medical Services Fund and the amount of the reimbursement they~~
7 ~~have received. This listing shall be compiled on a semiannual basis.~~

8 ~~SEC. 8. Section 113807 is added to the Health and Safety Code,~~
9 ~~to read:~~

10 ~~113807. “Hotdog” means a whole, cured, cooked sausage that~~
11 ~~is skinless or stuffed in a casing, may be served in a bun or roll,~~
12 ~~and is also known as a bologna, frank, frankfurter, furter, garlic~~
13 ~~bologna, knockwurst, red hot, Vienna, or wiener.~~

14 ~~SEC. 9. Section 113953.3 of the Health and Safety Code is~~
15 ~~amended to read:~~

16 ~~113953.3. (a) Except as specified in subdivision (b), all~~
17 ~~employees shall thoroughly wash their hands and that portion, if~~
18 ~~any, of their arms exposed to direct food contact with cleanser and~~
19 ~~warm water by vigorously rubbing together the surfaces of their~~
20 ~~lathered hands and arms for at least 10 to 15 seconds and~~
21 ~~thoroughly rinsing with clean running water followed by drying~~
22 ~~of cleaned hands and that portion, if any, of their arms exposed.~~
23 ~~Employees shall pay particular attention to the areas underneath~~
24 ~~the fingernails and between the fingers. Employees shall wash~~
25 ~~their hands in all of the following instances:~~

26 ~~(1) Immediately before engaging in food preparation, including~~
27 ~~working with nonprepackaged food, clean equipment and utensils,~~
28 ~~and unwrapped single-use food containers and utensils.~~

29 ~~(2) After touching bare human body parts other than clean hands~~
30 ~~and clean, exposed portions of arms.~~

31 ~~(3) After using the toilet room.~~

32 ~~(4) After caring for or handling any animal allowed in a food~~
33 ~~facility pursuant to this part.~~

34 ~~(5) After coughing, sneezing, using a handkerchief or disposable~~
35 ~~tissue, using tobacco, eating, or drinking.~~

36 ~~(6) After handling soiled equipment or utensils.~~

37 ~~(7) During food preparation, as often as necessary to remove~~
38 ~~soil and contamination and to prevent cross-contamination when~~
39 ~~changing tasks.~~

~~(8) When switching between working with raw food and working with ready-to-eat food.~~

~~(9) Before dispensing or serving food or handling clean tableware and serving utensils in the food service area.~~

~~(10) After engaging in other activities that contaminate the hands.~~

~~(11) Before initially donning gloves for working with food and before donning gloves to replace gloves that were changed or replaced due to the circumstances described in paragraphs (2) to (10), inclusive.~~

~~(b) If approved and capable of removing the types of soils encountered in the food operations involved, an automatic handwashing facility may be used by food employees to clean their hands.~~

~~SEC. 10. Section 113973 of the Health and Safety Code is amended to read:~~

~~113973. (a) Gloves shall be worn when contacting food and food-contact surfaces if the employee has any cuts, sores, rashes, artificial nails, nail polish, rings (other than a plain ring, such as a wedding band), uncleanable orthopedic support devices, or fingernails that are not clean, smooth, or neatly trimmed.~~

~~(b) Whenever gloves, except single-use gloves, are worn, they shall be changed, replaced, or washed as often as handwashing is required by this part.~~

~~(c) If single-use gloves are used, single-use gloves shall be used for only one task, such as working with ready-to-eat food or with raw food of animal origin, used for no other purpose, and shall be discarded when damaged or soiled, or when interruptions in the food handling occur. Single-use gloves shall not be washed.~~

~~(d) Except as specified in subdivision (c), slash-resistant gloves that are used to protect the hands during operations requiring cutting shall be used only with food that is subsequently cooked as specified in Section 114004, such as frozen food or a primal cut of meat.~~

~~(e) Slash-resistant gloves may be used with ready-to-eat food that will not be subsequently cooked if the slash-resistant gloves have a smooth, durable, and nonabsorbent outer surface or if the slash-resistant gloves are covered with a smooth, durable, nonabsorbent glove, or a single-use glove.~~

1 ~~(f) Cloth gloves may not be used in direct contact with food~~
2 ~~unless the food is subsequently cooked.~~

3 ~~SEC. 11. Section 113975 is added to the Health and Safety~~
4 ~~Code, to read:~~

5 ~~113975. (a) Except as provided in subdivision (b), an employee~~
6 ~~who has a lesion or wound that is open or draining shall not handle~~
7 ~~food.~~

8 ~~(b) In addition to wearing gloves when contacting food and~~
9 ~~food-contact surfaces, a food employee who has a cut, sore, rash,~~
10 ~~lesion, or wound shall do all of the following:~~

11 ~~(1) If the lesion is located on the hand or wrist, an impermeable~~
12 ~~cover, such as a finger cot or stall shall protect the lesion. A~~
13 ~~single-use glove shall be worn over the impermeable cover.~~

14 ~~(2) If the lesion is located on exposed portions of the arms, an~~
15 ~~impermeable cover shall protect the lesion.~~

16 ~~(3) If the lesion is located on other parts of the body, a dry,~~
17 ~~durable, tight-fitting bandage shall cover the lesion.~~

18 ~~SEC. 12.~~

19 ~~SEC. 3. Section 121022 of the Health and Safety Code is~~
20 ~~amended to read:~~

21 ~~121022. (a) To ensure knowledge of current trends in the HIV~~
22 ~~epidemic and to ensure that California remains competitive for~~
23 ~~federal HIV and AIDS funding, health care providers and~~
24 ~~laboratories shall report cases of HIV infection to the local health~~
25 ~~officer using patient names on a form developed by the department.~~
26 ~~Local health officers shall report unduplicated HIV cases by name~~
27 ~~to the department on a form developed by the department.~~

28 ~~(b) (1) Health care providers and local health officers shall~~
29 ~~submit cases of HIV infection pursuant to subdivision (a) by courier~~
30 ~~service, United States Postal Service express mail or registered~~
31 ~~mail, other traceable mail, person-to-person transfer, facsimile, or~~
32 ~~electronically by a secure and confidential electronic reporting~~
33 ~~system established by the department.~~

34 ~~(2) This subdivision shall be implemented using the existing~~
35 ~~resources of the department.~~

36 ~~(c) The department and local health officers shall ensure~~
37 ~~continued reasonable access to anonymous HIV testing through~~
38 ~~alternative testing sites, as established by Section 120890, and in~~
39 ~~consultation with HIV planning groups and affected stakeholders,~~

1 including representatives of persons living with HIV and health
2 officers.

3 (d) The department shall promulgate emergency regulations to
4 conform the relevant provisions of Article 3.5 (commencing with
5 Section 2641.5) of Chapter 4 of Division 1 of Title 17 of the
6 California Code of Regulations, consistent with this chapter, by
7 April 17, 2007. Notwithstanding the Administrative Procedure
8 Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of
9 Division 3 of Title 2 of the Government Code), if the department
10 revises the form used for reporting pursuant to subdivision (a) after
11 consideration of the reporting guidelines published by the federal
12 Centers for Disease Control and Prevention, the revised form shall
13 be implemented without being adopted as a regulation, and shall
14 be filed with the Secretary of State and printed in Title 17 of the
15 California Code of Regulations.

16 (e) Pursuant to Section 121025, reported cases of HIV infection
17 shall not be disclosed, discoverable, or compelled to be produced
18 in any civil, criminal, administrative, or other proceeding.

19 (f) State and local health department employees and contractors
20 shall be required to sign confidentiality agreements developed by
21 the department that include information related to the penalties for
22 a breach of confidentiality and the procedures for reporting a breach
23 of confidentiality, prior to accessing confidential HIV-related
24 public health records. Those agreements shall be reviewed annually
25 by either the department or the appropriate local health department.

26 (g) No person shall disclose identifying information reported
27 pursuant to subdivision (a) to the federal government, including,
28 but not limited to, any agency, employee, agent, contractor, or
29 anyone else acting on behalf of the federal government, except as
30 permitted under subdivision (b) of Section 121025.

31 (h) (1) Any potential or actual breach of confidentiality of
32 HIV-related public health records shall be investigated by the local
33 health officer, in coordination with the department, when
34 appropriate. The local health officer shall immediately report any
35 evidence of an actual breach of confidentiality of HIV-related
36 public health records at a city or county level to the department
37 and the appropriate law enforcement agency.

38 (2) The department shall investigate any potential or actual
39 breach of confidentiality of HIV-related public health records at

1 the state level, and shall report any evidence of such a breach of
2 confidentiality to an appropriate law enforcement agency.

3 (i) Any willful, negligent, or malicious disclosure of cases of
4 HIV infection reported pursuant to subdivision (a) shall be subject
5 to the penalties prescribed in Section 121025.

6 (j) Nothing in this section shall be construed to limit other
7 remedies and protections available under state or federal law.

8 ~~SEC. 13. Section 123149.5 of the Health and Safety Code is~~
9 ~~amended to read:~~

10 ~~123149.5. (a) It is the intent of the Legislature that all medical~~
11 ~~information transmitted during the delivery of health care via~~
12 ~~telehealth, as defined in subdivision (a) of Section 2290.5 of the~~
13 ~~Business and Professions Code, become part of the patient's~~
14 ~~medical record maintained by the licensed health care provider.~~

15 ~~(b) This section shall not be construed to limit or waive any of~~
16 ~~the requirements of Chapter 1 (commencing with Section 123100)~~
17 ~~of Part 1 of Division 106 of the Health and Safety Code.~~

18 ~~SEC. 14. Section 127620 of the Health and Safety Code is~~
19 ~~amended to read:~~

20 ~~127620. (a) The Office of Statewide Health Planning and~~
21 ~~Development, in conjunction with the State Department of Public~~
22 ~~Health, shall act as the coordinating agency to develop a strategic~~
23 ~~plan that would assist rural California to prepare for health care~~
24 ~~reform. The plan shall assist in the coordination and integration~~
25 ~~of all rural health care services on the birth to death continuum~~
26 ~~and serve as an infrastructure for rural communities to establish~~
27 ~~priorities and develop appropriate programs.~~

28 ~~(b) The office shall designate representatives from provider~~
29 ~~groups including rural hospitals, clinics, physicians, other rural~~
30 ~~providers including psychologists, counties, beneficiaries, and~~
31 ~~other entities directly affected by the plan. The office shall convene~~
32 ~~meetings with the objectives of doing all of the following:~~

33 ~~(1) Assessing the current status of health care in rural~~
34 ~~communities.~~

35 ~~(2) Assembling and reviewing data related to available~~
36 ~~programs and resources for rural California.~~

37 ~~(3) Assembling and reviewing data related to other states'~~
38 ~~strategic plans for rural communities.~~

39 ~~(4) Reviewing and integrating the office's rural work plan, as~~
40 ~~appropriate.~~

1 ~~(5) Making assumptions about the future of health care and~~
2 ~~developing a strategic plan based on these assumptions.~~

3 ~~(c) The rural health care strategic plan shall address all of the~~
4 ~~following:~~

5 ~~(1) The special needs of the elderly and of ethnic populations.~~

6 ~~(2) Elimination of barriers in planning and coordinating health~~
7 ~~services.~~

8 ~~(3) The lack of primary and specialty providers.~~

9 ~~(4) Access to emergency services.~~

10 ~~(5) The role of new technologies, including, but not limited to,~~
11 ~~telehealth.~~

12 ~~SEC. 15. Section 130302 of the Health and Safety Code is~~
13 ~~amended to read:~~

14 ~~130302. For the purposes of this division, the following~~
15 ~~definitions apply:~~

16 ~~(a) "Director" means the Director of the Office of Health~~
17 ~~Information Integrity.~~

18 ~~(b) "HIPAA" means the federal Health Insurance Portability~~
19 ~~and Accountability Act.~~

20 ~~(c) "Office" means the Office of Health Information Integrity~~
21 ~~established in the California Health and Human Services Agency~~
22 ~~pursuant to Section 130200.~~

23 ~~(d) "State entities" means all state departments, boards,~~
24 ~~commissions, programs, and other organizational units of the~~
25 ~~executive branch of state government.~~

26 ~~SEC. 16. Section 130304 of the Health and Safety Code is~~
27 ~~repealed.~~

28 ~~SEC. 17. Section 130307 of the Health and Safety Code is~~
29 ~~amended to read:~~

30 ~~130307. The director shall establish an advisory committee to~~
31 ~~obtain information on statewide HIPAA implementation activities.~~
32 ~~The advisory committee shall meet as required to coordinate~~
33 ~~statewide HIPAA implementation activities with other health care~~
34 ~~stakeholders. It is the intent of the Legislature that the committee's~~
35 ~~membership include representatives from county government,~~
36 ~~from consumers, and from a broad range of provider groups, such~~
37 ~~as physicians and surgeons, clinics, hospitals, pharmaceutical~~
38 ~~companies, health care service plans, disability insurers, long-term~~
39 ~~care facilities, facilities for the developmentally disabled, and~~
40 ~~mental health providers. The director shall invite key stakeholders~~

1 from the federal government, the Judicial Council, health care
2 advocates, nonprofit health care organizations, public health
3 systems, and the private sector to provide information to the
4 committee.

5 SEC. 18. Section 130309 of the Health and Safety Code is
6 repealed.

7 SEC. 19. Section 10123.13 of the Insurance Code is amended
8 to read:

9 10123.13. (a) Every insurer issuing group or individual policies
10 of health insurance that covers hospital, medical, or surgical
11 expenses, including those telehealth services covered by the insurer
12 as defined in subdivision (a) of Section 2290.5 of the Business and
13 Professions Code, shall reimburse claims or any portion of any
14 claim, whether in state or out of state, for those expenses as soon
15 as practical, but no later than 30 working days after receipt of the
16 claim by the insurer unless the claim or portion thereof is contested
17 by the insurer, in which case the claimant shall be notified, in
18 writing, that the claim is contested or denied, within 30 working
19 days after receipt of the claim by the insurer. The notice that a
20 claim is being contested or denied shall identify the portion of the
21 claim that is contested or denied and the specific reasons including
22 for each reason the factual and legal basis known at that time by
23 the insurer for contesting or denying the claim. If the reason is
24 based solely on facts or solely on law, the insurer is required to
25 provide only the factual or the legal basis for its reason for
26 contesting or denying the claim. The insurer shall provide a copy
27 of the notice to each insured who received services pursuant to the
28 claim that was contested or denied and to the insured's health care
29 provider that provided the services at issue. The notice shall advise
30 the provider who submitted the claim on behalf of the insured or
31 pursuant to a contract for alternative rates of payment and the
32 insured that either may seek review by the department of a claim
33 that the insurer contested or denied, and the notice shall include
34 the address, Internet Web site address, and telephone number of
35 the unit within the department that performs this review function.
36 The notice to the provider may be included on either the
37 explanation of benefits or remittance advice and shall also contain
38 a statement advising the provider of its right to enter into the
39 dispute resolution process described in Section 10123.137. The

1 notice to the insured may also be included on the explanation of
2 benefits.

3 (b) If an uncontested claim is not reimbursed by delivery to the
4 claimant's address of record within 30 working days after receipt,
5 interest shall accrue and shall be payable at the rate of 10 percent
6 per annum beginning with the first calendar day after the
7 30-working day period.

8 (c) For purposes of this section, a claim, or portion thereof, is
9 reasonably contested when the insurer has not received a completed
10 claim and all information necessary to determine payer liability
11 for the claim, or has not been granted reasonable access to
12 information concerning provider services. Information necessary
13 to determine liability for the claims includes, but is not limited to,
14 reports of investigations concerning fraud and misrepresentation;
15 and necessary consents, releases, and assignments, a claim on
16 appeal, or other information necessary for the insurer to determine
17 the medical necessity for the health care services provided to the
18 claimant. If an insurer has received all of the information necessary
19 to determine payer liability for a contested claim and has not
20 reimbursed a claim determined to be payable within 30 working
21 days of receipt of that information, interest shall accrue and be
22 payable at a rate of 10 percent per annum beginning with the first
23 calendar day after the 30-working day period.

24 (d) The obligation of the insurer to comply with this section
25 shall not be deemed to be waived when the insurer requires its
26 contracting entities to pay claims for covered services.

27 SEC. 20. Section 10123.147 of the Insurance Code is amended
28 to read:

29 10123.147. (a) Every insurer issuing group or individual
30 policies of health insurance that covers hospital, medical, or
31 surgical expenses, including those telehealth services covered by
32 the insurer as defined in subdivision (a) of Section 2290.5 of the
33 Business and Professions Code, shall reimburse each complete
34 claim, or portion thereof, whether in state or out of state, as soon
35 as practical, but no later than 30 working days after receipt of the
36 complete claim by the insurer. However, an insurer may contest
37 or deny a claim, or portion thereof, by notifying the claimant, in
38 writing, that the claim is contested or denied, within 30 working
39 days after receipt of the complete claim by the insurer. The notice
40 that a claim, or portion thereof, is contested shall identify the

1 portion of the claim that is contested, by revenue code, and the
2 specific information needed from the provider to reconsider the
3 claim. The notice that a claim, or portion thereof, is denied shall
4 identify the portion of the claim that is denied, by revenue code,
5 and the specific reasons for the denial, including the factual and
6 legal basis known at that time by the insurer for each reason. If
7 the reason is based solely on facts or solely on law, the insurer is
8 required to provide only the factual or legal basis for its reason to
9 deny the claim. The insurer shall provide a copy of the notice
10 required by this subdivision to each insured who received services
11 pursuant to the claim that was contested or denied and to the
12 insured's health care provider that provided the services at issue.
13 The notice required by this subdivision shall include a statement
14 advising the provider who submitted the claim on behalf of the
15 insured or pursuant to a contract for alternative rates of payment
16 and the insured that either may seek review by the department of
17 a claim that was contested or denied by the insurer and the address,
18 Internet Web site address, and telephone number of the unit within
19 the department that performs this review function. The notice to
20 the provider may be included on either the explanation of benefits
21 or remittance advice and shall also contain a statement advising
22 the provider of its right to enter into the dispute resolution process
23 described in Section 10123.137. An insurer may delay payment
24 of an uncontested portion of a complete claim for reconsideration
25 of a contested portion of that claim so long as the insurer pays
26 those charges specified in subdivision (b).

27 (b) If a complete claim, or portion thereof, that is neither
28 contested nor denied, is not reimbursed by delivery to the
29 claimant's address of record within the 30 working days after
30 receipt, the insurer shall pay the greater of fifteen dollars (\$15)
31 per year or interest at the rate of 10 percent per annum beginning
32 with the first calendar day after the 30-working-day period. An
33 insurer shall automatically include the fifteen dollars (\$15) per
34 year or interest due in the payment made to the claimant, without
35 requiring a request therefor.

36 (c) For the purposes of this section, a claim, or portion thereof,
37 is reasonably contested if the insurer has not received the completed
38 claim. A paper claim from an institutional provider shall be deemed
39 complete upon submission of a legible emergency department
40 report and a completed UB-92 or other format adopted by the

~~1 National Uniform Billing Committee, and reasonable relevant
2 information requested by the insurer within 30 working days of
3 receipt of the claim. An electronic claim from an institutional
4 provider shall be deemed complete upon submission of an
5 electronic equivalent to the UB-92 or other format adopted by the
6 National Uniform Billing Committee, and reasonable relevant
7 information requested by the insurer within 30 working days of
8 receipt of the claim. However, if the insurer requests a copy of the
9 emergency department report within the 30 working days after
10 receipt of the electronic claim from the institutional provider, the
11 insurer may also request additional reasonable relevant information
12 within 30 working days of receipt of the emergency department
13 report, at which time the claim shall be deemed complete. A claim
14 from a professional provider shall be deemed complete upon
15 submission of a completed HCFA 1500 or its electronic equivalent
16 or other format adopted by the National Uniform Billing
17 Committee, and reasonable relevant information requested by the
18 insurer within 30 working days of receipt of the claim. The provider
19 shall provide the insurer reasonable relevant information within
20 15 working days of receipt of a written request that is clear and
21 specific regarding the information sought. If, as a result of
22 reviewing the reasonable relevant information, the insurer requires
23 further information, the insurer shall have an additional 15 working
24 days after receipt of the reasonable relevant information to request
25 the further information, notwithstanding any time limit to the
26 contrary in this section, at which time the claim shall be deemed
27 complete.~~

~~28 (d) This section shall not apply to claims about which there is
29 evidence of fraud and misrepresentation, to eligibility
30 determinations, or in instances where the plan has not been granted
31 reasonable access to information under the provider's control. An
32 insurer shall specify, in a written notice to the provider within 30
33 working days of receipt of the claim, which, if any, of these
34 exceptions applies to a claim.~~

~~35 (e) If a claim or portion thereof is contested on the basis that
36 the insurer has not received information reasonably necessary to
37 determine payer liability for the claim or portion thereof, then the
38 insurer shall have 30 working days after receipt of this additional
39 information to complete reconsideration of the claim. If a claim,
40 or portion thereof, undergoing reconsideration is not reimbursed~~

1 by delivery to the claimant's address of record within the 30
2 working days after receipt of the additional information, the insurer
3 shall pay the greater of fifteen dollars (\$15) per year or interest at
4 the rate of 10 percent per annum beginning with the first calendar
5 day after the 30-working-day period. An insurer shall automatically
6 include the fifteen dollars (\$15) per year or interest due in the
7 payment made to the claimant, without requiring a request therefor.

8 (f) An insurer shall not delay payment on a claim from a
9 physician or other provider to await the submission of a claim from
10 a hospital or other provider, without citing specific rationale as to
11 why the delay was necessary and providing a monthly update
12 regarding the status of the claim and the insurer's actions to resolve
13 the claim, to the provider that submitted the claim.

14 (g) An insurer shall not request or require that a provider waive
15 its rights pursuant to this section.

16 (h) This section shall apply only to claims for services rendered
17 to a patient who was provided emergency services and care as
18 defined in Section 1317.1 of the Health and Safety Code in the
19 United States on or after September 1, 1999.

20 (i) This section shall not be construed to affect the rights or
21 obligations of any person pursuant to Section 10123.13.

22 (j) This section shall not be construed to affect a written
23 agreement, if any, of a provider to submit bills within a specified
24 time period.

25 SEC. 21 Section 10181.11 of the Insurance Code is amended
26 to read:

27 10181.11. (a) Whenever it appears to the department that any
28 person has engaged, or is about to engage, in any act or practice
29 constituting a violation of this article, including the filing of
30 inaccurate or unjustified rates or inaccurate or unjustified rate
31 information, the department may review the rate filing to ensure
32 compliance with the law.

33 (b) The department may review other filings.

34 (c) The department shall accept and post to its Internet Web site
35 any public comment on a rate increase submitted to the department
36 during the 60-day period described in subdivision (d) of Section
37 10181.7.

38 (d) The department shall report to the Legislature at least
39 quarterly on all unreasonable rate filings.

1 ~~(e) The department shall post on its Internet Web site any~~
2 ~~changes submitted by the insurer to the proposed rate increase,~~
3 ~~including any documentation submitted by the insurer supporting~~
4 ~~those changes.~~

5 ~~(f) If the department finds that an unreasonable rate increase is~~
6 ~~not justified or that a rate filing contains inaccurate information,~~
7 ~~the department shall post its finding on its Internet Web site.~~

8 ~~(g) Nothing in this article shall be construed to impair or impede~~
9 ~~the department's authority to administer or enforce any other~~
10 ~~provision of this code.~~

11 ~~SEC. 22. Section 10198.7 of the Insurance Code is amended~~
12 ~~to read:~~

13 ~~10198.7. (a) No health benefit plan that covers three or more~~
14 ~~persons and that is issued, renewed, or written by any insurer,~~
15 ~~nonprofit hospital service plan, self-insured employee welfare~~
16 ~~benefit plan, fraternal benefits society, or any other entity shall~~
17 ~~exclude coverage for any individual on the basis of a preexisting~~
18 ~~condition provision for a period greater than six months following~~
19 ~~the individual's effective date of coverage, nor shall limit or~~
20 ~~exclude coverage for a specific insured person by type of illness,~~
21 ~~treatment, medical condition, or accident except for satisfaction~~
22 ~~of a preexisting clause pursuant to this article. Preexisting condition~~
23 ~~provisions contained in health benefit plans may relate only to~~
24 ~~conditions for which medical advice, diagnosis, care, or treatment,~~
25 ~~including use of prescription drugs, was recommended or received~~
26 ~~from a licensed health practitioner during the six months~~
27 ~~immediately preceding the effective date of coverage.~~

28 ~~(b) No health benefit plan that covers one or two individuals~~
29 ~~and that is issued, renewed, or written by any insurer, self-insured~~
30 ~~employee welfare benefit plan, fraternal benefits society, or any~~
31 ~~other entity shall exclude coverage on the basis of a preexisting~~
32 ~~condition provision for a period greater than 12 months following~~
33 ~~the individual's effective date of coverage, nor shall limit or~~
34 ~~exclude coverage for a specific insured person by type of illness,~~
35 ~~treatment, medical condition, or accident, except for satisfaction~~
36 ~~of a preexisting condition clause pursuant to this article. Preexisting~~
37 ~~condition provisions contained in health benefit plans may relate~~
38 ~~only to conditions for which medical advice, diagnosis, care, or~~
39 ~~treatment, including use of prescription drugs, was recommended~~

1 or received from a licensed health practitioner during the 12 months
2 immediately preceding the effective date of coverage.

3 (e) (1) ~~Notwithstanding subdivision (a), a health benefit plan~~
4 ~~for group coverage shall not impose any preexisting condition~~
5 ~~provision upon any child under 19 years of age.~~

6 (2) ~~Notwithstanding subdivision (b), a health benefit plan for~~
7 ~~individual coverage that is not a grandfathered plan within the~~
8 ~~meaning of Section 1251 of the federal Patient Protection and~~
9 ~~Affordable Care Act (Public Law 111-148) shall not impose any~~
10 ~~preexisting condition provision upon any child under 19 years of~~
11 ~~age.~~

12 (d) ~~A carrier that does not utilize a preexisting condition~~
13 ~~provision may impose a waiting or affiliation period not to exceed~~
14 ~~60 days, before the coverage issued subject to this article shall~~
15 ~~become effective. During the waiting or affiliation period, the~~
16 ~~carrier is not required to provide health care services and no~~
17 ~~premium shall be charged to the subscriber or enrollee.~~

18 (e) ~~A carrier that does not utilize a preexisting condition~~
19 ~~provision in health plans that cover one or two individuals may~~
20 ~~impose a contract provision excluding coverage for waived~~
21 ~~conditions. No carrier may exclude coverage on the basis of a~~
22 ~~waivered condition for a period greater than 12 months following~~
23 ~~the individual's effective date of coverage. A waived condition~~
24 ~~provision contained in health benefit plans may relate only to~~
25 ~~conditions for which medical advice, diagnosis, care, or treatment,~~
26 ~~including use of prescription drugs, was recommended or received~~
27 ~~from a licensed health practitioner during the 12 months~~
28 ~~immediately preceding the effective date of coverage.~~

29 (f) ~~In determining whether a preexisting condition provision, a~~
30 ~~waivered condition provision, or a waiting or affiliation period~~
31 ~~applies to any person, all health benefit plans shall credit the time~~
32 ~~the person was covered under creditable coverage, provided the~~
33 ~~person becomes eligible for coverage under the succeeding health~~
34 ~~benefit plan within 62 days of termination of prior coverage,~~
35 ~~exclusive of any waiting or affiliation period, and applies for~~
36 ~~coverage under the succeeding plan within the applicable~~
37 ~~enrollment period. A health benefit plan shall also credit any time~~
38 ~~an eligible employee must wait before enrolling in the health~~
39 ~~benefit plan, including any affiliation or employer-imposed waiting~~
40 ~~period. However, if a person's employment has ended, the~~

1 availability of health coverage offered through employment or
2 sponsored by an employer has terminated or, an employer's
3 contribution toward health coverage has terminated, a carrier shall
4 credit the time the person was covered under creditable coverage
5 if the person becomes eligible for health coverage offered through
6 employment or sponsored by an employer within 180 days,
7 exclusive of any waiting or affiliation period, and applies for
8 coverage under the succeeding plan within the applicable
9 enrollment period.

10 (g) No health benefit plan that covers three or more persons and
11 that is issued, renewed, or written by any insurer, nonprofit hospital
12 service plan, self-insured employee welfare benefit plan, fraternal
13 benefits society, or any other entity may exclude late enrollees
14 from coverage for more than 12 months from the date of the late
15 enrollee's application for coverage. No insurer, nonprofit hospital
16 service plan, self-insured employee welfare benefit plan, fraternal
17 benefits society, or any other entity shall require any premium or
18 other periodic charge to be paid by or on behalf of a late enrollee
19 during the period of exclusion from coverage permitted by this
20 subdivision.

21 (h) An individual's period of creditable coverage shall be
22 certified pursuant to subdivision (e) of Section 2701 of Title XXVII
23 of the federal Public Health Services Act, 42 U.S.C. Sec. 300gg(e).

24 (i) A group health benefit plan may not impose a preexisting
25 condition exclusion to a condition relating to benefits for pregnancy
26 or maternity care.

27 (j) Any entity providing aggregate or specific stop loss coverage
28 or any other assumption of risk with reference to a health benefit
29 plan shall provide that the plan meets all requirements of this article
30 concerning waiting periods, preexisting condition provisions, and
31 late enrollees.

32 SEC. 23.— Section 10953 of the Insurance Code is amended to
33 read:

34 10953. (a) Upon the effective date of this chapter, a carrier
35 shall fairly and affirmatively offer, market, and sell all of the
36 carrier's health benefit plans that are offered and sold to a child
37 or the responsible party for a child in each service area in which
38 the plan provides or arranges for health care coverage during any
39 open enrollment period, to late enrollees, and during any other
40 period in which state or federal law, rules, regulations, or guidance

1 expressly provide that a carrier shall not condition offer or
2 acceptance of coverage on any preexisting condition.

3 (b) No carrier, agent, or broker shall, directly or indirectly,
4 engage in the following activities:

5 (1) Encourage or direct a child or responsible party for a child
6 to refrain from filing an application for coverage with a carrier
7 because of the health status, claims experience, industry,
8 occupation, or geographic location, provided that the location is
9 within the carrier's approved service area, of the child.

10 (2) Encourage or direct a child or responsible party for a child
11 to seek coverage from another carrier because of the health status,
12 claims experience, industry, occupation, or geographic location,
13 provided that the location is within the carrier's approved service
14 area, of the child.

15 (c) A carrier shall not, directly or indirectly, enter into any
16 contract, agreement, or arrangement with an agent or broker of the
17 carrier that provides for or results in the payment of compensation
18 to the agent or broker for the sale of a health benefit plan to be
19 varied because of the health status, claims experience, industry,
20 occupation, or geographic location of the child. This subdivision
21 does not apply to a compensation arrangement that provides
22 compensation to an agent or broker of a carrier on the basis of
23 percentage of premium, provided that the percentage shall not vary
24 because of the health status, claims experience, industry,
25 occupation, or geographic area of the child.

26 SEC. 24. Section 10959 of the Insurance Code is amended to
27 read:

28 10959. (a) All health benefit plans offered to a child or on
29 behalf of a child to a responsible party for a child shall conform
30 to the requirements of Sections 10127.18, 10273.6, and 12682.1,
31 and shall be renewable at the option of the child or responsible
32 party for a child on behalf of the child except as permitted to be
33 canceled, rescinded, or not renewed pursuant to Section 10273.6.

34 (b) Any carrier that ceases to offer for sale new individual health
35 benefit plans pursuant to Section 10273.6 shall continue to be
36 governed by this chapter with respect to business conducted under
37 this chapter.

38 (c) Except as authorized under Section 10958, a carrier that as
39 of the effective date of this chapter does not write new health
40 benefit plans for children in this state or that after the effective

~~date of this chapter ceases to write new health benefit plans for children in this state shall be prohibited from offering for sale new individual health benefit plans or in this state for a period of five years from the date of notice to the commissioner.~~

SEC. 4. Section 10144.51 is added to the Insurance Code, to read:

10144.51. (a) (1) Every health insurance policy issued, amended, or renewed on or after July 1, 2012, shall provide coverage for behavioral health treatment for pervasive developmental disorder or autism. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 10144.5.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individualized service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400, et seq.) and its implementing regulations.

(b) Pursuant to Article 6 (commencing with Section 2240.1) of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Nothing shall prevent a health insurer from selectively contracting with providers within these requirements.

1 (c) For the purposes of this section, the following definitions
2 shall apply:

3 (1) “Behavioral health treatment” means professional services
4 and treatment programs, including applied behavior analysis and
5 other behavior intervention programs, that develop or restore, to
6 the maximum extent practicable, the functioning of an individual
7 with pervasive developmental disorder or autism, and that meet
8 all of the following criteria:

9 (A) The treatment is prescribed by a physician and surgeon
10 licensed pursuant to Chapter 5 (commencing with Section 2000)
11 of, or a psychologist licensed pursuant to Chapter 6.6 (commencing
12 with Section 2900) of, Division 2 of the Business and Professions
13 Code.

14 (B) The treatment is provided under a treatment plan prescribed
15 by a qualified autism service provider and is administered by one
16 of the following:

17 (i) A qualified autism service provider.

18 (ii) A qualified autism service professional supervised and
19 employed by the qualified autism service provider.

20 (iii) A qualified autism service paraprofessional supervised and
21 employed by a qualified autism service provider.

22 (C) The treatment plan has measurable goals over a specific
23 timeline that is developed and approved by the qualified autism
24 service provider for the specific patient being treated. The
25 treatment plan shall be reviewed no less than once every six months
26 by the qualified autism service provider and modified whenever
27 appropriate, and shall be consistent with Section 4686.2 of the
28 Welfare and Institutions Code pursuant to which the qualified
29 autism service provider does all of the following:

30 (i) Describes the patient’s behavioral health impairments to be
31 treated.

32 (ii) Designs an intervention plan that includes the service type,
33 number of hours, and parent participation needed to achieve the
34 plan’s goal and objectives, and the frequency at which the patient’s
35 progress is evaluated and reported.

36 (iii) Provides intervention plans that reflect evidence-based
37 practices, with demonstrated clinical efficacy in treating pervasive
38 developmental disorder or autism.

1 (iv) *Discontinues intensive behavioral intervention services*
2 *when the treatment goals and objectives are achieved or no longer*
3 *appropriate.*

4 (D) *The treatment plan is not prescribed for purposes of*
5 *providing respite, day care, or school services and is not used to*
6 *reimburse a parent for participating in the treatment program.*
7 *The treatment plan shall be made available to the insurer upon*
8 *request.*

9 (2) *“Pervasive developmental disorder or autism” shall have*
10 *the same meaning and interpretation as used in Section 10144.5.*

11 (3) *“Qualified autism service provider” means either of the*
12 *following:*

13 (A) *A person, entity, or group that is certified by a national*
14 *entity, such as the Behavior Analyst Certification Board, that is*
15 *accredited by the National Commission for Certifying Agencies,*
16 *and who designs, supervises, or provides treatment for pervasive*
17 *developmental disorder or autism, provided the services are within*
18 *the experience and competence of the person, entity, or group that*
19 *is nationally certified.*

20 (B) *A person licensed as a physician and surgeon, physical*
21 *therapist, occupational therapist, psychologist, marriage and*
22 *family therapist, educational psychologist, clinical social worker,*
23 *professional clinical counselor, speech-language pathologist, or*
24 *audiologist pursuant to Division 2 (commencing with Section 500)*
25 *of the Business and Professions Code, who designs, supervises,*
26 *or provides treatment for pervasive developmental disorder or*
27 *autism, provided the services are within the experience and*
28 *competence of the licensee.*

29 (4) *“Qualified autism service professional” means an individual*
30 *who meets all of the following criteria:*

31 (A) *Provides behavioral health treatment.*

32 (B) *Is employed and supervised by a qualified autism service*
33 *provider.*

34 (C) *Provides treatment pursuant to a treatment plan developed*
35 *and approved by the qualified autism service provider.*

36 (D) *Is a behavioral service provider approved as a vendor by*
37 *a California regional center to provide services as an Associate*
38 *Behavior Analyst, Behavior Analyst, Behavior Management*
39 *Assistant, Behavior Management Consultant, or Behavior*

1 *Management Program as defined in Section 54342 of Title 17 of*
2 *the California Code of Regulations.*

3 *(E) Has training and experience in providing services for*
4 *pervasive developmental disorder or autism pursuant to Division*
5 *4.5 (commencing with Section 4500) of the Welfare and Institutions*
6 *Code or Title 14 (commencing with Section 95000) of the*
7 *Government Code.*

8 *(5) “Qualified autism service paraprofessional” means an*
9 *unlicensed and uncertified individual who meets all of the following*
10 *criteria:*

11 *(A) Is employed and supervised by a qualified autism service*
12 *provider.*

13 *(B) Provides treatment and implements services pursuant to a*
14 *treatment plan developed and approved by the qualified autism*
15 *service provider.*

16 *(C) Meets the criteria set forth in the regulations adopted*
17 *pursuant to Section 4686.3 of the Welfare and Institutions Code.*

18 *(D) Has adequate education, training, and experience, as*
19 *certified by a qualified autism service provider.*

20 *(d) This section shall not apply to the following:*

21 *(1) A specialized health insurance policy that does not cover*
22 *mental health or behavioral health services or an accident only,*
23 *specified disease, hospital indemnity, or Medicare supplement*
24 *policy.*

25 *(2) A health insurance policy in the Medi-Cal program (Chapter*
26 *7 (commencing with Section 14000) of Part 3 of Division 9 of the*
27 *Welfare and Institutions Code).*

28 *(3) A health insurance policy in the Healthy Families Program*
29 *(Part 6.2 (commencing with Section 12693) of Division 2 of the*
30 *Insurance Code).*

31 *(4) A health care benefit plan or policy entered into with the*
32 *Board of Administration of the Public Employees’ Retirement*
33 *System pursuant to the Public Employees’ Medical and Hospital*
34 *Care Act (Part 5 (commencing with Section 22750) of Division 5*
35 *of Title 2 of the Government Code).*

36 *(e) Nothing in this section shall be construed to limit the*
37 *obligation to provide services under Section 10144.5.*

38 *(f) Notwithstanding any other provision of law, in the provision*
39 *of benefits required by this section, a health insurer may utilize*

1 case management, network providers, utilization review techniques,
2 prior authorization, copayments, or other cost sharing.

3 (g) This section shall become inoperative on July 1, 2014, and,
4 as of January 1, 2015, is repealed, unless a later enacted statute,
5 that becomes operative on or before January 1, 2015, deletes or
6 extends the dates on which it becomes inoperative and is repealed.

7 SEC. 5. Section 10144.52 is added to the Insurance Code, to
8 read:

9 10144.52. (a) For purposes of this part, the terms “provider,”
10 “professional provider,” “network provider,” “mental health
11 provider,” and “mental health professional” shall include the
12 term “qualified autism service provider,” as defined in subdivision
13 (c) of Section 10144.51.

14 (b) This section shall become inoperative on July 1, 2014, and,
15 as of January 1, 2015, is repealed, unless a later enacted statute,
16 that becomes operative on or before January 1, 2015, deletes or
17 extends the dates on which it becomes inoperative and is repealed.

18 ~~SEC. 25.~~

19 SEC. 6. Section 5705 of the Welfare and Institutions Code is
20 amended to read:

21 5705. (a) It is the intent of the Legislature that the use of
22 negotiated net amounts, as provided in this section, be given
23 preference in contracts for services under this division.

24 (b) Negotiated net amounts may be used as the cost of services
25 in contracts between the state and the county or contracts between
26 the county and a subprovider of services, or both. A negotiated
27 net amount shall be determined by calculating the total budget for
28 services for a program or a component of a program, less the
29 amount of projected revenue. All participating government funding
30 sources, except for the Medi-Cal program (Chapter 7 (commencing
31 with Section 14000) of Part 3 of Division 9), shall be bound to
32 that amount as the cost of providing all or part of the total county
33 mental health program as described in the county performance
34 contract for each fiscal year, to the extent that the governmental
35 funding source participates in funding the county mental health
36 programs. Where the State Department of Health Care Services
37 promulgates regulations for determining reimbursement of
38 Short-Doyle mental health services allowable under the Medi-Cal
39 program, those regulations shall be controlling as to the rates for
40 reimbursement of Short-Doyle mental health services allowable

1 under the Medi-Cal program and rendered to Medi-Cal
2 beneficiaries. Providers under this subdivision shall report to the
3 State Department of Mental Health and local mental health
4 programs any information required by the State Department of
5 Mental Health in accordance with procedures established by the
6 Director of Mental Health.

7 (c) Notwithstanding any other provision of this division or
8 Division 9 (commencing with Section 10000), absent a finding of
9 fraud, abuse, or failure to achieve contract objectives, no
10 restrictions, other than any contained in the contract, shall be placed
11 upon a provider's expenditure pursuant to this section.

12 ~~SEC. 26.~~

13 *SEC. 7.* Section 5708 of the Welfare and Institutions Code is
14 amended to read:

15 5708. To maintain stability during the transition, counties that
16 contracted with the department during the 1990–91 fiscal year on
17 a negotiated net amount basis may continue to use the same funding
18 mechanism.

19 ~~SEC. 27.~~

20 *SEC. 8.* Section 5710 of the Welfare and Institutions Code is
21 amended to read:

22 5710. (a) Charges for the care and treatment of each patient
23 receiving service from a county mental health program shall not
24 exceed the actual cost thereof as determined or approved by the
25 Director of Mental Health in accordance with standard accounting
26 practices. The director may include the amount of expenditures
27 for capital outlay or the interest thereon, or both, in his or her
28 determination of actual cost. The responsibility of a patient, his or
29 her estate, or his or her responsible relatives to pay the charges
30 and the powers of the director with respect thereto shall be
31 determined in accordance with Article 4 (commencing with Section
32 7275) of Chapter 3 of Division 7.

33 (b) The Director of Mental Health may delegate to each county
34 all or part of the responsibility for determining the financial liability
35 of patients to whom services are rendered by a county mental
36 health program and all or part of the responsibility for determining
37 the ability of the responsible parties to pay for services to minor
38 children who are referred by a county for treatment in a state
39 hospital. Liability shall extend to the estates of patients and to
40 responsible relatives, including the spouse of an adult patient and

1 the parents of minor children. The Director of Mental Health may
2 also delegate all or part of the responsibility for collecting the
3 charges for patient fees. Counties may decline this responsibility
4 as it pertains to state hospitals, at their discretion. If this
5 responsibility is delegated by the director, the director shall
6 establish and maintain the policies and procedures for making the
7 determinations and collections. Each county to which the
8 responsibility is delegated shall comply with the policy and
9 procedures.

10 (c) The director shall prepare and adopt a uniform sliding scale
11 patient fee schedule to be used in all mental health agencies for
12 services rendered to each patient. In preparing the uniform patient
13 fee schedule, the director shall take into account the existing
14 charges for state hospital services and those for community mental
15 health program services. If the director determines that it is not
16 practicable to devise a single uniform patient fee schedule
17 applicable to both state hospital services and services of other
18 mental health agencies, the director may adopt a separate fee
19 schedule for the state hospital services which differs from the
20 uniform patient fee schedule applicable to other mental health
21 agencies.

22 ~~SEC. 28.~~

23 *SEC. 9.* Section 5716 of the Welfare and Institutions Code is
24 amended to read:

25 5716. Counties may contract with providers on a negotiated
26 net amount basis in the same manner as set forth in Section 5705.

27 ~~SEC. 29.~~

28 *SEC. 10.* Section 5724 of the Welfare and Institutions Code is
29 amended to read:

30 5724. (a) The department and the State Department of Health
31 Care Services shall jointly develop a new ratesetting methodology
32 for use in the Short-Doyle Medi-Cal system that maximizes federal
33 funding and utilizes, as much as practicable, federal medicare
34 reimbursement principles. The departments shall work with the
35 counties and the federal Health Care Financing Administration in
36 the development of the methodology required by this section.

37 (b) Rates developed through the methodology required by this
38 section shall apply only to reimbursement for direct client services.

39 (c) Administrative costs shall be claimed separately and shall
40 be limited to 15 percent of the total cost of direct client services.

1 (d) The cost of performing utilization reviews shall be claimed
2 separately and shall not be included in administrative cost.

3 (e) The rates established for direct client services pursuant to
4 this section shall be based on increments of time for all
5 noninpatient services.

6 (f) The ratesetting methodology shall not be implemented until
7 it has received any necessary federal approvals.

8 ~~SEC. 30.~~

9 *SEC. 11.* Section 5750.1 of the Welfare and Institutions Code
10 is amended to read:

11 5750.1. Notwithstanding Section 5750, a standard, rule, or
12 policy, not directly the result of a statutory or administrative law
13 change, adopted by the department or county during the term of
14 an existing county performance contract shall not apply to the
15 negotiated net amount terms of that contract under Sections 5705
16 and 5716, but shall only apply to contracts established after
17 adoption of the standard, rule, or policy.

18 ~~SEC. 31. Section 14132.73 of the Welfare and Institutions~~
19 ~~Code is amended to read:~~

20 ~~14132.73. The State Department of Health Care Services shall~~
21 ~~allow psychiatrists to receive fee-for-service Medi-Cal~~
22 ~~reimbursement for services provided through telehealth until June~~
23 ~~30, 2004, or until the State Department of Mental Health and~~
24 ~~mental health plans, in collaboration with stakeholders, develop a~~
25 ~~method for reimbursing psychiatric services provided through~~
26 ~~telehealth that is administratively feasible for the mental health~~
27 ~~plans, primary care providers, and psychiatrists providing the~~
28 ~~services, whichever occurs later.~~

29 ~~SEC. 32. No reimbursement is required by this act pursuant to~~
30 ~~Section 6 of Article XIII B of the California Constitution for certain~~
31 ~~costs that may be incurred by a local agency or school district~~
32 ~~because, in that regard, this act creates a new crime or infraction,~~
33 ~~eliminates a crime or infraction, or changes the penalty for a crime~~
34 ~~or infraction, within the meaning of Section 17556 of the~~
35 ~~Government Code, or changes the definition of a crime within the~~
36 ~~meaning of Section 6 of Article XIII B of the California~~
37 ~~Constitution.~~

38 ~~However, if the Commission on State Mandates determines that~~
39 ~~this act contains other costs mandated by the state, reimbursement~~
40 ~~to local agencies and school districts for those costs shall be made~~

1 pursuant to Part 7 (commencing with Section 17500) of Division
2 4 of Title 2 of the Government Code.

3 *SEC. 12. No reimbursement is required by this act pursuant*
4 *to Section 6 of Article XIII B of the California Constitution because*
5 *the only costs that may be incurred by a local agency or school*
6 *district will be incurred because this act creates a new crime or*
7 *infraction, eliminates a crime or infraction, or changes the penalty*
8 *for a crime or infraction, within the meaning of Section 17556 of*
9 *the Government Code, or changes the definition of a crime within*
10 *the meaning of Section 6 of Article XIII B of the California*
11 *Constitution.*